GLAUCOMA ASSOCIATES OF TEXAS

RONALD L. FELLMAN, M.D.
DAVID G. GODFREY, M.D.
OLUWATOSIN U. SMITH, M.D.
DAVINDER S. GROVER, M.D., M.P.H.
MICHELLE R. BUTLER, M.D.
MATTHEW E. EMANUEL, M.D.

RELEASE OF MEDICAL RECORDS

To: _____

From: _____
(Patient's name)

This is to request that you release copies of the above named patient's medical records, registration forms, correspondence and materials pertinent to the patient's care. Include chart dictation, procedure notes, flow sheets, GDx, OCT, VF, ORB, photographs, past medication and allergies.

Please send this information to:

Glaucoma Associates of Texas
10740 N. Central Expwy.
Suite 300
Dallas, Tx. 75231

Signed:_____
(Signature of patient or person responsible for patient)

_____
Relationship

Date: _____