Records Release Request

DATE: _____

TO: Dr. _____

FAX: _____

Or Mailing Address:

_____
_____
_____

Please send a copy of my:

- Last vision evaluation including prescriptions, fields, OCT and photos
- Entire medical file

To:

Dr. Marisa Atria Kruger, O.D.
VISION TRANSFORMATION, INC
2535 S Lewis Way, Suite 209, Lakewood, CO 80227

FAX: 303-865-4294
mail@visiontransformation.net

_____ Birth Date: _____
Patient Name

_____ Birth Date: _____
Patient Name

_____ Birth Date: _____
Patient Name

_____ Birth Date: _____
Patient Name

Records Release Request

_____
Patient (Parent) Signature