

VISION FIRST EYECARE SPECIALISTS

Dr. L. Page Pond, O.D.

Dr. Joy Hansen, O.D.

Medical Records Release

I consent to the disclosure of my personal health information to or from the parties mentioned in the communication instructions below. I understand that the information disclosed may include data referencing past or current diagnosis, examination records, treatment, and/or any additional facts or observations related to my health care. I also understand that this information cannot be released without my consent (except in the case of a medical emergency, federal audit or court order), and that I have the right to revoke my consent at any time.

I hereby request that my complete medical records be:

Released From **or** *Released to*

Vision First Eyecare: Aurora Location

15320 E. ALAMEDA PKWY.
AURORA, CO. 80017
PHONE: 303-745-9400
FAX: 303-369-5212

Vision First Eyecare: Lowry Location

200 QUEBEC ST. BLDG. 600A, STE. 107
DENVER, CO. 80230
PHONE: 303-361-6600
FAX: 303-361-6604

I hereby request that my complete medical records be:

Released From **or** *Released to*

Doctor/Office: _____

Address: _____

Phone: _____ Fax: _____

Printed Name of Patient: _____ Today's Date: _____

Patient Date of Birth: _____

Signature of Patient or Parent/Legal Guardian: _____