Medical Records Request to SMOC

Provider/Entity: _____

Address: _____

City / State / Zip: _____

Secure email: _____

Fax: _____

Information Requested:

I _____ (patient full name) authorize the above-named provider/entity to release the following designated medical information.

- ☐ Copy of complete medical records including results of diagnostic testing
- ☐ Copy of spectacle lens and contact lens prescription
- ☐ Other information_____

Release Authorized to:

Southern Montana Optometric Center, Inc
PO Box 190
Laurel, MT, 59044
Fax: (406) 628-8702 **Secure email: Office@smocvision.com**

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. IF I AM SIGNING FOR A MINOR, MY SIGNATURE ATTESTS THAT I HAVE LEGAL AUTHORITY OVER MEDICAL DECISIONS FOR THE DESIGNATED MINOR(S).

(List minors, family members) _____
_____
_____

_____
Print Name& DOB (unless signing for minor)

_____ Date _____ / _____ / _____
Patient or legally authorized individual signature

_____ DOB of Minor_____
Printed name if signed on behalf of the patient (Designate parent or guardian & DOB of minor (if signing for minor)