Fall River Vision

Medical Records Release Form

Patient Name: _____

Address: _____

City: _____ State: _____ Zip/Postal Code:_____

Telephone: _____ Fax: _____ Email: _____

Date of Birth: _____ Social Security Number: _____

I authorize (name of PCP/medical provider) _____ to release my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment to be FAXED to: **Fall River Vision/Integrity Eye Care, LLC. Fax: (508) 673-5834**.

Fall River Vision/Integrity Eye Care, LLC
3950 N Main St.
Fall River, MA 02720

Phone: (508) 673-2370

Fax: (508) 673-5834

Patient/Medical Representative Signature: _____ Date: _____