MEIER & MOSER
ASSOCIATES, P.C.

Comprehensive Family Eye Care

Stephen P. Meier, Jr., O.D.
Leigh A. Moser, O.D.

RECORDS RELEASE

DATE: _____

TO: _____
(Doctor or Hospital)

_____
(Address)

This is to authorize and request you to release to:

_____
(Doctor or Hospital)

_____
(Address)

The complete medical records in your possession, concerning my illness and/or treatment during the period

FROM: _____ TO: _____

PATIENT'S NAME _____
(Please Print)

SIGNED: _____
(Patient or Legal Guardian)

_____
(Witness)

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