MAPLE GROVE
EYE CARE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

_____ _____
Patient Name Date of Birth

_____
STREET ADDRESS CITY ST ZIP

TO: _____
Name

_____
Address

_____
City, State, Zip

(_____)_____
Phone

(_____)_____
Fax

From:
MAPLE GROVE EYE CARE
8955 W. HACKAMORE DR.
BOISE, ID 83709

Ph: (208) 344-7944
Fax: (208) 343-4676

I hereby authorize you to release my medical records in your possession concerning my illness and/or treatment. This authorization is good for 90 days from the date of my signature unless revoked by me in writing.

_____ _____
Signature of Patient or Guardian Date