

PEREZ EYE CARE

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REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

NAME (PRINT)

ADDRESS

CITY, STATE, ZIP

I HEREBY REQUEST THAT MY MEDICAL RECORDS BE RELEASED TO:

**PEREZ EYE CARE
25 E WASHINGTON ST., SUITE 820
CHICAGO, IL 60602**

PATIENT'S NAME (PRINT)

PATIENT'S SIGNATURE

ADDRESS

BIRTH DATE
