Dr. Sergio A. Guzman, Ltd. • Optometrist

1184 College Avenue • Elko, Nevada 89801 • (775) 777-3937

RECORDS RELEASE

DATE: _____

TO: _____
Doctor's Name and/or Facility Name

_____
Address

I hereby authorize you to release any and all information including diagnosis and records of treatment and/or examinations rendered to me during the period:

_____ to _____

Please mail or fax all information mentioned above to:

Sergio A. Guzman, O.D.
Doctor's Name and/or Facility Name

1184 College Avenue Elko, Nevada 89801
Doctor and/or Facility Address

The facility, staff, and optometrists are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

_____ _____
Name of Patient Patient's Signature

_____ _____
Patient's Date of Birth Patient Address

Witness Signature: _____

Authorization for records release expires one year after today's date.