

SPARTANBURG VISION – WEST
DR. TOM MACMILLAN, OD DR. JEREMY ANDERSON, OD
DR. LEANN GEERTS, OD

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO:		FROM:
Dr.		Spartanburg Vision - West
COMPANY:		DATE:
FAX NUMBER:		TOTAL NO. OF PAGES INCLUDING COVER:
		1
PHONE NUMBER:		SENDER'S REFERENCE NUMBER:
RE:		
Request Release of Medical Records		

L CONFIDENTIALITY NOTICE: THIS FACSIMILE TRANSMISSION AND THE ACCOMPANYING DOCUMENTS MAY CONTAIN CONFIDENTIAL INFORMATION, WHICH IS PROTECTED BY THE PHYSICIAN/PATIENT PRIVILEGE. THIS INFORMATION IS INTENDED ONLY FOR THE USE OF THE INDIVIDUAL OR ENTITY NAMED ABOVE. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT THE LAW STRICTLY PROHIBITS ANY DISCLOSURE, COPYING OR DISTRIBUTION OF THIS INFORMATION. IF YOU HAVE RECEIVED THIS TRANSMISSION IN ERROR, PLEASE NOTIFY US IMMEDIATELY BY PHONE.

DEAR DR.: _____

Our office hereby requests you to release a report of diagnosis, prognosis and recommendations, as well as other data pertinent to your treatment. We appreciate your time and assistance in this matter.

Patient Name: _____ **Date of Birth:** ____/____/____

Social Security #: _____ - _____ - _____

Please Fax Records to: 864-576-0594

Sincerely,

Tom MacMillan, OD Jeremy Anderson, OD Leann Geerts, OD

Patient or Guardian Signature X _____

227 E. BLACKSTOCK RD., STE 200 SPARTANBURG, SC 29301
PHONE: 864-576-0564 FAX: 864-576-0594

PAGE 1

PAGE 2