High Country
macula, retina, and vitreous, pc

MEDICAL RECORD RELEASE

Date: _____

Doctor records are being requested FROM (Referring/PCP): _____

Fax: _____

We have currently received a referral of a mutual patient. Please supply the following Medical Records for the care of this patient. Do not hesitate to call our office if you have any questions. Thanks!

PATIENT: _____

Date of Birth: _____

Phone Number: _____

Records of: _____
_____
_____
_____
_____

Restrictions to released information:
_____
_____
_____

I, _____, expressly authorize the release of my medical records to High Country Macula, Retina, and Vitreous, PC, and Dr. Seligson.

_____
Patient Signature **Date**

Please fax or mail to:

High Country Macula, Retina, and Vitreous, PC
465 ST. MICHAEL'S DRIVE, SUITE 205
SANTA FE, NEW MEXICO, 87505
Fax: (505) 982-5718
For questions call: (505) 982-5716

Please fax or mail to:

High Country Macula, Retina, and Vitreous, PC
4343 PAN AMERICAN FWY NE, SUITE 224
ALBUQUERQUE, NEW MEXICO, 87107
Fax: (505) 344-5404
For questions call: (505) 344-5400

For Staff Use Only: Date Request Faxed/Mailed: _____ Employee Initials: _____
Date Records Received: _____ Employee Initials: _____