# ANIMAL EYE CARE CLINICS

PO Box 1228
2150 Pickwick Drive Camarillo, CA 93012
P: 805-388-3933

## REQUEST FOR RELEASE OF MEDICAL RECORDS

Client name:_____

Address:_____

City, State, Zip: _____

Phone number:_____

Email:_____

I hereby request that the Animal Eye Care Clinics provide a summary of the medical records (Visit Summaries) for my animal named: _____. I request that these medical records (visit summaries)

A) Be released to me: (Please allow 72hrs for processing, we will inform you when records are ready for pick up)

- ☐ mail to me (please enclose a self-addressed, stamped envelope)
- ☐ Email (fill in email address, above)

-Or

B) Released to my new veterinary ophthalmologist:

Ophthalmologist name:_____

Clinic Name:_____

Address:_____

City, State, Zip:_____

Phone number:_____

Fax number:_____

Appointment date & time:_____

Signature:_____ Date:_____