



SIERRA  
EYE CARE

Authorization for Release of Medical Records

Patient name \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize and request a copy of my complete medical record to be released and disclosed:

TO / FROM (please circle):

Sierra Eye Care  
Colin B. Arnold, MD  
7501 Hospital Drive, Suite 105  
Sacramento, California 95823  
(916) 423-4040 (916) 689-7800  
Fax (916) 689-2100

TO / FROM (please circle):

Physician/Optomtrist \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Reason for request:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
*Patient Signature (Legal Guardian if Minor)*

\_\_\_\_\_  
*Date*