5280 Vision Care

9220 Kimmer Drive #140, Lone Tree, CO 80124
Ph: 303-754-0122 Fax: 303-754-3176
www.5280visioncare.com

Records Release Request

TO: _____

PHONE: _____

FAX: _____

I, _____ DOB: _____

Request that you release to Dr. Trisha C. Rogers, OD and Dr. Helen R. Wilson, OD, a complete copy of my patient records, including, but not limited to any diagnosis, treatment, prognosis, recommendations, lab results, visual fields, glasses prescriptions and contact lens data that you have on record for the past 2 years, or the last two most recent exams.

Patient Signature: _____

Date of Request: _____

Witness: _____