Stuart K Harrell, OD

Request for Release of Medical Records

Date: _____

To: Physician's Name _____

Address _____

City _____ State _____ Zip _____

Records Requested:

Examinations Visual Fields Optic Nerve OCT's Macular OCT's

From _____ To _____

I hereby request that my medical records be released to:

Dr. Stuart K. Harrell

2602 James Redman Pkwy

Plant City, FL 33566

Fax: 813-754-4432 Phone: 813-752-5838

Patient's Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Patient's Signature: _____ Date: _____