BIG SKY EYES

Dr. Erica Perlman O.D.
99 Town Center Avenue
Unit A6, P.O.Box 160700
Big Sky, MT 59716

Release of Records Request

Today's Date: _____/_____/_____

Patient's Name: _____ Date of Birth: _____/_____/_____

Parent or Guardian (if minor): _____

Mailing Address: _____ City: _____ Zip: _____

Email: _____ Phone: (_____)_____

I authorize the release of my medical records to Big Sky Eyes and Dr. Erica Perlman. This healthcare information incudes intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment during the period of _____ to _____.

Other Medical Office: _____

Mailing Address: _____ City: _____ Zip: _____

Email: _____ Phone: (_____)_____

Fax: (_____)_____

Patient Signature: _____ Date: _____/_____/_____