MEDICAL RECORDS REQUEST

FROM:

Previous Office/Doctor Name, Address, Phone Number, Fax Number:

____

Patient Name ____

Patient D.O.B.____

Parent/Guardian Name____

TO:

Please send copies of my medical records, including last exam, last glasses and/or contact lens prescription, and any visual fields or medical testing results __________________________ to

Kari Clark, O.D.
Frisco In Focus
11511 Independence Pkwy., Suite 102
Frisco, TX 75035
(972)478-0550
Fax (469) 444-5001

____ ______________________________
Patient Signature Date

____ ______________________________
Parent/Guardian Signature (if under 18) Relationship to Patient