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Request For Medical Records

I hereby authorize you, _____ (current provider), to release any information including but not limited to ocular and refractive diagnoses, pertinent findings and records of any treatment from my past visit(s) to your office ranging from _____ to _____. Please send all correspondence to the above address on my behalf. Thank you for your prompt attention to this request.

Patient's Name (Printed): _____

D.O.B. ___ / ___ / ___

Patient's Signature: _____

Date: _____