SUMMIT EYE CLINIC, S.C.
608 East Summit Avenue
Oconomowoc, WI 53066
Telephone: (262) 567-6565
Fax: (262) 567-8214

RELEASE OF RECORDS

Date: _______/_______/_______

Patient Name: ______________________________________

Patient Date of Birth: _______/_______/_______

I hereby release my records

FROM: SUMMIT EYE CLINIC, S.C.
608 East Summit Avenue
Oconomowoc, WI 53066
(262) 567-6565

TO: ☐ Self

☐ The office of:

Name: ______________________________

Address: ______________________________

____

Phone: ______________________________

____
Signature of Patient or Legal Guardian