

Patient Medical Records Release Form

Date: _____

Dr. _____

Please release a complete copy of my records to:

Caplan Eye Clinic
3409 North Hullen Street, Suite 100
Metairie, LA 70002-3485

FAX: 504-456-9596, Tel 504-888-2600

Patient Name: _____

Address: _____

Patient Signature: _____

Comments: Please include contact lens information &/or visual fields if applicable.
