Request for Release of Medical Records

□ DR. PAUL KIMBALL

From: FULL CIRCLE VISION CARE □ DR. CARL ERICKSON

PHYSICIAN'S NAME

217 N Saginaw Rd

ADDRESS

Midland	MI	48640
CITY	STATE	ZIP CODE

(989) 631-2653	(989) 631-0893
TELEPHONE	FAX

I hereby request that my medical records be released to :

To: _____

PHYSICIAN'S NAME

_____

ADDRESS

_____

CITY STATE ZIP CODE

_____

TELEPHONE FAX (IF APPLICABLE)

/ /

PRINT PATIENT NAME **DATE OF BIRTH**

PATIENT'S SIGNATURE (IF MINOR, PARENT'S) ***DATE***

COMMENTS: