



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:

PATIENT'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: