Dr. Tauseef Tahir & Staff • Ph: 815-744-3222 • Fax: 815-744-3519 • www.JolietEyeCare.com

Date: _____/_____/_____

Patient: Last Name: _____ **First:** _____ **DOB:** _____/_____/_____

☐ **Release of Records TO Joliet EyeCare Associates:**

I, _____, request the release of my exam records. Please fax the last 1-2 years of my records and or any other pertinent information regarding my care. If Dr. Tahir needs more information he may request as needed.

RELEASE TO:

Joliet EyeCare Associates
301 Springfield Ave
Joliet IL 60435

Phone: 815-744-3222
Fax: 815-744-3519

FROM:

_____

_____

_____

☐ **Release of Records FROM Joliet EyeCare Associates to another office:**

Last Exam or a "Summary of your Exam plus any pertinent information," will be sent to the Eye Doctor listed below via Fax, for free. In most cases this information is sufficient for your eye healthcare. If further information is requested or the full release of your records is required, there is a fee $15 to $50 and up to 5 days requirement.

If you have any questions regarding medical record copying fee visit www.isms.org or http://www.ilga.gov/legislation/

I, _____, request the release of my exam records transferred to:

TRANSFER MY RECOREDS TO (MUST BE FILLED IN FULL):

Name of Facility: _____

Ph:_____ Fax: _____

Address: _____ City:_____ St:_____ Zip:_____

Printed Name: _____ **Signature:** _____

Date: _____/____/_____

Print Save