

**BARBARA E. EVANS, M.D.**  
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**REQUEST FOR RELEASE OF MEDICAL RECORDS**

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Previous Name: (if applicable) \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**This will authorize:**

Dr. Barbara E Evans, M.D.

To release the information listed below to:

Doctor's Name and Facility: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Doctors Email address: \_\_\_\_\_  
Doctors Fax Number: \_\_\_\_\_

- Medical and Exam information
- Glasses Prescription
- Contact Lens Prescription

**THIS WILL AUTHORIZE FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW. I SPECIFICALLY AUTHORIZE THE RELEASE OF DATA AND INFORMATION RELATING TO:**

**Circle One:**

- |     |    |    |   |
|-----|----|----|---|
| Yes | or | No | Substance abuse (alcohol/drug use)                        |
| Yes | or | No | Mental Health/Depression (includes psychological testing) |
| Yes | or | No | HIV related information/AIDS testing                      |

**This authorization will automatically expire one year from the date of signature or until \_\_\_\_\_. I understand that I may revoke this consent at any time by notifying the above-named provider of information. Any release of information made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality.**

**RESTRICTIONS: This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law.**

Signature of Patient or legal guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
Relationship if not patient: \_\_\_\_\_

*For office use only.* Faxed to: \_\_\_\_\_ By: \_\_\_\_\_ Date: \_\_\_\_\_