RECORD TRANSFER REQUEST

Patient's Name: ______________________________

Patient's Date of Birth: ______________________________

Patient's Phone Number: ______________________________

Patient's Address: ______________________________

____

I direct that all my records be transferred from ______________________________

All records for contii nuing care. **TO:** ______________________________

Patient's Signature: ______________________________

Date: ______________________________

Photocopy shall be as valid as original. **Expires one year from date signed.**
This release may be revoked in writing at any time.

John C. Foley, M.D.

1570 Concordia Avenue, Suite 201 St. Paul, MN 55104 • 14655 Galaxie Avenue Apple Valley, MN 55124
T: (651) 287-2020 • F: (651) 294-2020 • info@foleyeyeclinic.com • www.foleyeyeclinic.com