

Medical Records Release

Name of Patient

Date of Birth

Street Address

City, State and Zip

Authorizes:

Name of Physician

Street Address

City, State and Zip

Release my Medical Records to:

P. Vernon Jones, M.D. Ophthalmologist

Name of Physician

1550 Riverside Ave.

Street Address

Jacksonville, FL 32204

City, State and Zip

I authorize release of my medical records.

Signature of Patient