70+ Years of Excellence

GTOC
GRAND TRAVERSE OPHTHALMOLOGY CLINIC

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The undersigned hereby authorized Grand Traverse Ophthalmology Clinic, PC (GTOC) (located at 929 Business Park Drive, Traverse City, Michigan 49686), its physicians, and medical records personnel to release or request medical records.

☐ I wish to release records from Grand Traverse Ophthalmology to:

-OR-

☐ I wish to request records be released to Grand Traverse Ophthalmology from:

(Dr./Clinic) _____

(Address) _____

(City/St/Zip)_____

Telephone:_____ Fax:_____

Concerning the care and treatment of: _____
(please print)

GTOC Account #:_____ DOB:_____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Records to be sent: ☐ All records on file ☐ Billing information

☐ Following specified records only:_____

_____

Dated:_____ Authorized Signature:_____

Unless otherwise notified this records release authorization will expire one year after the date signed above. This authorization can be revoked prior to the expiration date by submitting a written request to Grand Traverse Ophthalmology Clinic, P.C.

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