153 Manchester Street
Concord, NH 03301
Phone: 603-226-0855
Fax: 603-226-0981

Medical Records Request

We ask all new patients to please request your previous records in time for your eye exam with Capital Vision Center.

This signed form can be sent to your previous eye doctor directly or given to us and we can submit the request form on your behalf.

■ **Request:** I hereby authorize and request that you please transfer any and all medical records pertinent to my past ocular history to ***Capital Vision Center***
-Please include any special testing like VF/OCT when applicable

_____
Doctor's name

_____
Street address/city/state/zip

_____
Phone number / Fax number

_____ DOB: ___/___/_____ _____
Patient's name printed Signature (if guardian, state relationship)