Marvin H. Heimlich, OD
Kathleen T. Charo, OD

LIBERTYVILLE VISION CENTER
307 S. Milwaukee Ave
Libertyville, IL 60048
Ph: 847-362-3444 Fax: 847-362-4672

Blake W. Dowell, OD
Magdalena Stec, OD

REQUEST FOR PATIENT RECORDS

To: ______________________________ Ph#____________ Fax#__________

Address:____

____ The below-named patient is being referred to your office; record summary provided below.

____ The below-named patient is being seen at our office for Vision Care; please send records to 307 S. Milwaukee Ave., Libertyville, IL 60048; or fax to [847] 362-4672.

Patient Name: __________________________ DOB: ________ Phone:__________

Address:____

Reason for request of history: ____

Records Requested: Request Expires: ____________

____ All records prior to date:____________

____ Latest Visual Acuities and spectacle Rx

Date: __________ OD: 20/____ Rx_______________________Add +______

OS: 20/____ Rx_______________________Add +______

____ Contact Lens Specifications: Material/Lens type: ___________________________

OD: bc______ dia: ______ power ______________________ pc _________

OS: bc______ dia: ______ power ______________________ pc _________

____ “K” readings: OD: ___________________ OS: ___________________

____ Tonometry [IOP] : OD: _______ OS: ________

____ Slit Lamp Examinatino [SLE] : ___________________________________

____ Visual Fields (circle one): NORMAL ABNORMAL NONE AVAILABLE
Please enclose copies if available

____Internal: C/D _______ Disk _______ A/V _______ Macula ________

Peripheral fundus ________________________________

____ Other pertinent findings: ______________________________________

If you sign this authorization, you may revoke it later, in writing. The only exception to your right to revoke is if we have already acted in reliance upon the authorization.
When your health information is disclosed as provided in this authorization, it may be re-disclosed if deemed necessary by the recipient, and not restricted by law.

It is completely your decision whether or not to sign; and your treatment is not conditional to signing this authorization.

Signature: __________________________ [ ] Parent/Guardian Date: _________