Evergreen Vision Clinic, P.C.
Daniel R. Hock, O.D.,F.A.A.O.,F.C.O.V.D.
30960 Stagecoach Blvd Suite 200
Evergreen, CO. 80439
(303) 674-4143 Phone
(303) 670-4081 Fax

Date: _____

Please release my records to:

Company Name: _____

Company Address: _____

Company Phone Number: _____

Company Email: _____

Records Being Requested: _____

Please note all records will be sent via encrypted email to ensure optimal safety and security of the patient.

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

Patient Phone: _____

Patient Email: _____

Patient Signature: _____

I understand there may be a fees associated with this request unless requested by a health care professional. Per Colorado regulations the fees are as follows: Minimum charge of $14.00 for the first ten or fewer pages. $0.50 per pages 11-40 and $0.33 for each additional page. If a patient would like their own records we can give access electronically at no cost if method indicated on request is self and email included. Records will be released as soon as possible upon; please note records can take up to three weeks to process.

Original documents will:
_____ Follow by regular mail
_____ Not be sent