

# Records Release Request

Date \_\_\_\_\_

Doctor \_\_\_\_\_

I authorize the release of vision and/or medical records, or copies thereof, and request that they are transferred to:



Neil K. Dickerson, O.D.

8660 W Cheyenne Ave, Ste 120  
Las Vegas, NV 89129-7455

Phone (702) 790-2400  
Fax (702) 790-2441  
eyecare@infocusnv.com

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

X \_\_\_\_\_

Patient, Parent, or Legal Guardian Signature