



**CENTRAL OHIO EYECARE, INC.**  
**3130 Olentangy River Road**  
**Columbus, Ohio 43202**  
**(614) 262-2020**

**Patient Request for Medical Records**

Dr. \_\_\_\_\_

I hereby request that all medical records documenting care that I have received in your office be forwarded to Central Ohio EyeCare, Inc. I acknowledge that Central Ohio EyeCare, Inc. will become my primary eye care providers and I am waiving any privileges I may have to the confidentiality of this information and authorize you to release said information as soon as possible.

Thank you for your prompt attention to this request.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date