FRISCO IN FOCUS
OUR FOCUS IS YOUR EYES

MEDICAL RECORDS REQUEST

Please send to your previous eye care doctor

Patient Name _____D.O.B _____

Address_____

City_____State_____ Zip_____ Phone_____

Please send copies of my past 2 years of medical records, including exam notes, glasses and/or contact lens prescription, and any visual fields, OCTs, or medical testing results to

Kari Clark, O.D.
Frisco In Focus
11511 Independence Pkwy., Suite 102
Frisco, TX 75035
(972)478-0550
Fax (469) 444-5001

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if under 18) Relationship to Patient

Please send this form to your previous eye doctor's office at least one week prior to your visit with us if you would like us to have your previous records. We are unable to forward this on your behalf.