# RECORDS REQUEST

I hereby authorize the release of my records or copies of such to include

_____

_____

to be transferred to :

Bulverde Vision Source
121 Bulverde Crossing Suite 116
Bulverde, TX 78163
Phone: 830-980-2020
Fax: 830-438-2477

_____

Name of patient (please print)

_____ _____

Patient's signature Date