

**BUFFALO GROVE EYE CARE CENTER**

Marvin H. Heimlich, OD

**313 W. Dundee Road  
Buffalo Grove, IL 60089  
Ph: 847-541-1184 Fax: 847-541-1194**

Blake W. Dowell, OD  
Magdalena Stec, OD

**REQUEST FOR PATIENT RECORDS**

To: \_\_\_\_\_ Ph# \_\_\_\_\_ Fax# \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_ The below-named patient is being referred to your office; record summary provided below.

\_\_\_\_ The below-named patient is being seen at our office for Vision Care; please send records to  
313 W. Dundee Road., Buffalo Grove, IL 60089; or fax to [847] 541-1194

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Reason for request of history: \_\_\_\_\_

Records Requested: \_\_\_\_\_ Request Expires: \_\_\_\_\_

\_\_\_\_ All records prior to date: \_\_\_\_\_

\_\_\_\_ Latest Visual Acuities and spectacle Rx

Date: \_\_\_\_\_ OD: 20/ \_\_\_\_\_ Rx \_\_\_\_\_ Add + \_\_\_\_\_

OS: 20/ \_\_\_\_\_ Rx \_\_\_\_\_ Add + \_\_\_\_\_

\_\_\_\_ Contact Lens Specifications: Material/Lens type: \_\_\_\_\_

OD: bc \_\_\_\_\_ dia: \_\_\_\_\_ power \_\_\_\_\_ pc \_\_\_\_\_

OS: bc \_\_\_\_\_ dia: \_\_\_\_\_ power \_\_\_\_\_ pc \_\_\_\_\_

\_\_\_\_ "K" readings: OD: \_\_\_\_\_ OS: \_\_\_\_\_

\_\_\_\_ Tonometry [IOP] : OD: \_\_\_\_\_ OS: \_\_\_\_\_

\_\_\_\_ Slit Lamp Examinatino [SLE] : \_\_\_\_\_

\_\_\_\_ Visual Fields (circle one):    NORMAL    ABNORMAL    NONE AVAILABLE

Please enclose copies if available

\_\_\_\_ Internal: C/D \_\_\_\_\_ Disk \_\_\_\_\_ A/V \_\_\_\_\_ Macula \_\_\_\_\_

Peripheral fundus \_\_\_\_\_

\_\_\_\_ Other pertinent findings: \_\_\_\_\_

If you sign this authorization, you may revoke it later, in writing. The only exception to your right to revoke is if we have already acted in reliance upon the authorization.

When your health information is disclosed as provided in this authorization, it may be re-disclosed if deemed necessary by the recipient, and not restricted by law.

It is completely your decision whether or not to sign; and your treatment is not conditional to signing this authorization.

Signature: \_\_\_\_\_ [ ] Parent/Guardian    Date: \_\_\_\_\_