70 Years of Excellence

GTOC
GRAND TRAVERSE OPHTHALMOLOGY CLINIC

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The undersigned hereby authorized Grand Traverse Ophthalmology Clinic, PC (GTOC) (located at 929 Business Park Drive, Traverse City, Michigan 49686), its physicians, and medical records personnel to release or request medical records.

I wish to release records from Grand Traverse Ophthalmology to:

(Dr./Clinic): _____

(Address) _____

(City/St/Zip) _____

Telephone: _____ Fax: _____

Concerning the care and treatment of: _____

GTOC Acct #: _____ DOB: _____

Relationship to Patient: _____

Records to be sent:
- ☐ All Records on File
- ☐ Billing Records Only
- ☐ Specific Records as follows:

_____

Dated:_____ **Authorized Signature**:_____

Unless otherwise notified this records release authorization will expire one year after the date signed above. This authorization can be revoked prior to the expiration date by submitting a written request to Grand Traverse Ophthalmology Clinic, P.C.

Fax medical records to: **231-947-8864**
E-mail medical records to: **gtocfax@gtoc.net (only used for medical records)**