Dr. Francis L. Pinard, OD & Associates
Green Mountain Eye Care
439 Washington Hwy
Morrisville VT 05661
Ph: 802-888-3089 Fax: 802-888-5391

Request for Record Transfer

Name:______________________________ DOB:_________
Address:____________________________
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☐ I hereby authorize and request that **you transfer to** Francis L. Pinard, OD & Associates and Green Mountain Eye Care the complete medical records in your possession pertinent to my present or past ocular/medical condition.

☐ I hereby authorize and request that Francis L. Pinard, OD & Associates and Green Mountain Eye Care, **transfer to you** the complete medical records in your possession pertinent to my present or past ocular/medical condition.

To: Doctor______________________ Fax:_______________
Address:______________________________________

Signature:_______________________ Date:____________
Witness:_________________________