

Vision Source

115 WEST GRAND AVE SUITE 120
RAINBOW CITY, AL 35906

T: 256-442-9350

RECORDS TRANSFER REQUEST

Date: _____

To: _____
(Doctor/Facility)

I hereby authorize the release of my patient records or copies of such and request they be transferred to:

DR. APRIL R. KING
115 West Grand Avenue, Suite 120
Rainbow City, Alabama 35906
Phone: (256) 442-9350 Fax (256) 442-9352

Patient Name (please print)

Date of Birth

Signature (patient, parent, or guardian)