1220 W. Higgins Rd, Suite 102
Hoffman Estates, IL 60169
Ph: 847-755-9393
Fax: 847-755-1560

Date: ______________________________

To: ________________________________

Re: ____

DOB: ______________________________

Please send a copy of my medical records to the address indicated below:

If specific records ae being requested (contact lens prescriptions, LASIK post-op, specific dates of service, etc.) please list them here:

Signed (Patient): ____

A charge will apply to records requested on paper according to Illinois comptroller's office. Unless it is transmitted by fax to another physician. Payment is expected before records are released. Please see fee schedule below.

Handling charge	$28.44
Copy pages 1 through 25	$1.07
Copy pages 26 through 50	$0.71
Copy pages in excess of 50	$0.36

MACK
EYE
CENTER