Wendell Eye Care

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (Please Print)

Name:____________________ Date of Birth:___________________

Address:____

City:__________________ State:___________ Zip Code:_______

Phone:______________________

Please release records from/to:

Name:____

Telephone:_____________________________________

Fax:____

Please release a copy of:

_____ Medical records

_____ Most recent dated lens prescription including lens manufacturer and lens design information

_____ Most recent dated spectacle prescription

BY MY SIGNATURE, I AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS

Patient:_____________________________ Date:_______________