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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Information (please print)

Name: _____ Date of birth: _____

Address: _____

Phone: _____

Please release medical records to/from:

Name: _____

Phone: _____

Fax: _____

Please release a copy of:

_____ Medical Records

_____ Most recent frame manufacturer and lens design information

_____ Most recent prescription

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

PATIENT SIGNATURE: _____ DATE: _____