UPTOWN EYECARE & OPTICAL

Confidential Facsimile Transmittal

To: _____

Fax#: _____

Date: _____

Re: MEDICAL RECORDS RELEASE FROM UPTOWN EYECARE & OPTICAL

I, _____, DOB _____

hereby authorize Uptown EyeCare & Optical to release my medical records confidentially to (Doctor & Practice Name, Address, Phone, Fax#, Email):

_____

_____

Signature: _____, Date: _____

LET US ENHANCE YOUR LIFE WITH OUR PERSONALIZED EYE CARE

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www.uptowneyecareandoptical.com