UPTOWN EYECARE & OPTICAL

Confidential Facsimile Transmittal

To: ______________________________

Fax#: ______________________________

Date: ______________________________

Re: MEDICAL RECORDS RELEASE TO UPTOWN EYECARE & OPTICAL

Please fax, email or mail patient's medical records, including auxiliary testing such as VF, OCT, Topography & Retinal Photos (Attn: Dr. Friberg).
Our HIPPA-Compliant Email Address is: info@uptowneyecareandoptical.com

I, ______________________________, DOB ____________________

hereby authorize (Doctor & Practice Name, Address, Phone, Fax#, Email):

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to release my medical records confidentially to Uptown EyeCare & Optical.

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Signature: ______________________________, Date: ____________________

LET US ENHANCE YOUR LIFE WITH OUR PERSONALIZED EYE CARE

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