Eye & Vision Care

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Request for Release of Medical Records

Date: _____

I _____, authorize the release of information pertaining to my health condition and/or treatment during the periods in which services were conducted at Eye & Vision Care.
I hereby authorize you to release my medical records to:

_____
(Name of Company or Physician)

_____
(Street Address)

_____
(City, State, Zip)

_____
(Phone)

_____
(Fax)

_____ _____
(Patient Name) (Date Of Birth)

_____
(Patient Signature)