EDINBURGH OPTOMETRY CLINIC
EYE CARE SERVICES

Dr. Robert E. Miller
Dr. Vince Timpano
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OPTOMETRISTS

CONSENT TO RELEASE OF RECORDS

Date: _____

To: _____

Fax: _____

I hereby consent to disclosure of my oculovisual history and exam results from your office to the practitioner indicated below.

Patient Name: _____

Date of Birth: _____

Signature: _____

To be released to:

[ ] Dr. Robert E. Miller, B.Sc., O.D.

[ ] Dr. Vince Timpano, O.D.

[ ] Dr. Kathleen A. MacNeill, B.Sc., O.D.

[ ] Dr. Matthew D. Iley, B.Sc, O.D.

[ ] Dr. Melissa L. Furfaro, B.Sc., O.D.

[ ] _____

Comments: