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PATIENT RECORDS RELEASE AND AUTHORIZATION FORM

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____

RECORDS REQUESTED FROM:

Fax: _____

Phone: _____

RECORDS REQUESTED FROM:

Fax: _____

Phone: _____

Please release patient records concerning:

EYE GLASSES PRESCRIPTION

CONTACT LENS PRESCRIPTION

OTHER – PLEASE SPECIFY: _____

SEND RECORDS VIA (CIRCLE ONE) **MAIL** **FAX** **Fax to #** _____

I HEREBY AUTHORIZE YOU TO RELEASE ANY INFORMATION IN MY PATIENT FILE, INCLUDING EXAMINATIONS, TREATMENTS, AND ANY OTHER MEDICAL FINDINGS. BY INITIATING THIS REQUEST, I HEREBY RELEASE MY PRACTITIONER FROM ANY LAWS GOVERNING THE DISCLOSURE OF CONFIDENTIAL OR PRIVILEGED INFORMATION.

PATIENT SIGNATURE AND DATE: _____ DATE: _____