Authorization for Release of Records

Date: ___________________

Patient Name: ____ DOB : _______________

Address: ____

City, State, Zip: ____

Please Release:

( ) All medical records
( ) Medical records from ______________ to _____________
( ) Eyeglass Rx
( ) Contact lens Rx

Release Records to:

( ) Occhio Optometry

( ) ____
Clinic Name, address & phone/fax

____ ___________________
Patient Signature Date