Authorization for Release of Medical/Vision Records

Davis Optical and Family Eye Health Center

Date: ___________________________

I authorize the release of my medical/Vision records to: (Name and Address)

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____________________________________ ______________________________

Patients Signature Print Name

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Patient Date of Birth

For Internal Use:

Records Requested From: ____

Fax/Address: ____

Date Requested: _______________________________ By: __________________________________

Records Received From: ____

Date Received: ________________________________ By: __________________________________

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