ISTHMUS EYE CARE

VISION SOURCE

Patient Record Release Authorization

Patient's Name: _____

Patient's Date of Birth: _____

To Whom It Concerns:

I, _____ , authorize the release of my records and any pertinent information regarding my eye health care.

From:_____ To:_____

_____ _____

_____ _____

_____ _____

_____ _____

By my signature, I hereby authorize the release of my records or any information.

_____

Patient's name (Please print)

_____ _____

Patient's Signature (Parent, if minor) Date

Your Life. In Focus.

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