

Colin Connors, OD
Richard Jun, OD
Aja Kimrey, OD
Callie Maursetter, OD
Timothy Wilson, OD



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.