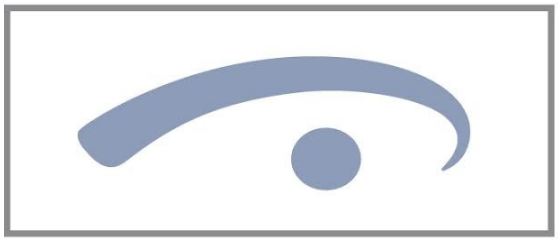

WEST MICHIGAN Eyecare ASSOCIATES

Transfer of Medical Records to West Michigan Eyecare Associates

Patient Information:

Name: _____

Date of Birth: _____ Phone Number_____

Address: _____

_____

Records requested from:
Doctor/office:_____

Office Phone: _____ Office Fax: _____

Records to be sent to:
West Michigan Eyecare Associates
2112 East Paris Ave SE
Grand Rapids, MI 49546

Phone: 616-949-8500
Fax: 616-949-2878

Appointment date (if applicable): _____

I hereby give authorization for the above named doctors to release any and all pertinent information from my case records to the doctors at West Michigan Eyecare Associates, including glasses and/or contact lens prescriptions, exam findings, and test results.

Patient Signature: _____ Date: _____

Special notes/requests:
_____
_____
_____
_____