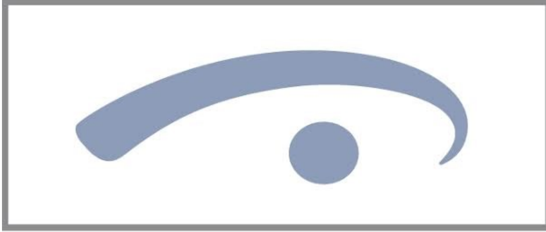

Authorization for Release of Medical Records

Patient Information:

Name: ____

Date of Birth: _______________ Phone Number: __________________________

Address: ____

____

Records to be sent to:

Doctor Name/Practice: ____

Office Location (address): ____

____

Office Phone: __________________________ Office Fax: ______________________

Appointment date (if applicable) _________________________

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

Patient Signature: _______________________________________ Date:_____________

Specials notes/requests:____

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