Authorization for release of Medical /Vision Records

Northshore Eye Care

Date: _____

I authorize the release of my medical / vision records to: (Name, Phone, Fax #, Address)

_____

_____

_____

_____

_____ _____

Patient Signature Print Name

_____

Patient Date of Birth

Record requested From: _____

Fax/ Address: _____

Date requested:_____ By: _____

Records Received From: _____

Date Received: _____ By: _____

Dr. Thunya Walker

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