Authorization to Release Vision Medical Information

Please release the records of:

Patient's Name: _____

Address: _____

_____

Date of Birth: _____

I authorize the release of my vision medical records from:

Eye Doctor's Name: _____

Address: _____
_____

To: Webster Eyecare Associates
81 East Main Street
Webster, NY 14580

585-265-3710 - Telephone
585-265-3775 – Fax

Please release all information including the diagnosis and records of any treatment, examination, or information in your possession concerning me.

Signature _____ Date _____