Sharp Vision

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I,_____authorize and request the release of my requested record(s) TO/FROM Sharp Vision.

PATIENT SIGNATURE:_____

DATE OF BIRTH:_____

TODAY'S DATE:_____

DOCTOR/CLINIC:_____

ADDRESS:_____

_____

PHONE:_____

FAX:_____

Information requesting for (please circle):

Contact Lenses

Glasses Prescriptions

Records (date range): _____