REQUEST FOR MEDICAL RECORD RELEASE OF INFORMATION

PATIENT NAME: _____

ADDRESS: _____

CITY: _____

DATE OF BIRTH: _____ SSN: _____

I HEREBY AUTHORIZE TO OBTAIN ANY AND ALL MEDICAL RECORDS, GLASSES AND CONTACT LENS PRESCRIPTIONS FROM _____ AND RELEASE TO ***PREFERRED EYE CARE, LLC.*** PLEASE FAX RECORDS TO 334 878-2025.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

*****PLEASE ONLY SEND THE LAST TWO NOTES UNLESS OTHERWISE REQUESTED*****