YOUR TWO eyes OPTOMETRY

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RECORDS RELEASE FORM

PATIENT NAME _____

DATE OF BIRTH _____

PHONE _____

I authorize the release of:

- ☐ COMPLETE HEALTH RECORD
  Please include medical history, current prescriptions, all imaging and all test results
- ☐ SPECTACLE PRESCRIPTIONS
- ☐ CONTACT LENS PRESCRIPTIONS
- ☐ OTHER _____

☐ *Send requested records to:* YOUR TWO EYES OPTOMETRY

☐ *Send requested records to:* _____

PHONE _____ FAX _____

SIGNATURE _____ DATE _____

REQUEST SENT: INITIAL: RECORDS RECEIVED: INITIAL: