REQUEST FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize: _____

_____

_____

to release copies of all medical records compiled during office visits and any additional testing.

Release Medical Records To:

Allentown Vision Center
939 Hamilton St
Allentown, PA 18101
Phone (610) 434-1000
Fax (610) 434 9592

Patient Name: _____

Date of Birth: _____

_____ _____

Patient Signature Date