

RECORD RELEASE AUTHORIZATION

Date: \_\_\_\_\_

I hereby authorize Eye Care Associates to release all information contained in the visual records for:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Please send to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature (If relative, please state relationship)

\_\_\_\_\_  
Witness