SPECIALTY Eyecare Group
a member of VISION SOURCE™

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Records Release Authorization

Patient Name: _____ DOB _____

Patient/Guardian Signature: _____ Date: _____

□ Incoming Records:

Doctor or Clinic requesting records from: _____

Address: _____

Phone: _____ Fax: _____

I hereby authorize and request you to release my medical and vision records to Specialty Eyecare Group.

□ Outgoing Records:

I hereby authorize Specialty Eyecare Group to furnish my eye health and vision records to:

Doctor or Clinic requesting records to be sent to: _____

Address: _____

Phone: _____ Fax: _____