Justin Verrone, O.D.
Benjamin Peters, O.D
Stephanie Lovett, O.D.
Shruti Pandya, O.D.
Kenneth Lindahl, M.D.

EYESITE

Authorization to Release Medical Information

Patient Name:	Patient Date of Birth:
Patient Address:	Patient Phone Number:

I authorize EYESITE to release/obtain information to/from:

Name of Provider:
Address:

Phone Number:

Fax Number:

TYPE OF RECORDS REQUESTED (circle appropriate item(s)):

Spectacle Prescription **Contact Lens Prescription**

Medical Records (specify if needed):

This consent will expire one year from date of signature:

_____ _____
Signature of Patient **Today's Date**

_____ _____
Signature of Parent or Guardian **Today's date**