



Dr. Bruce R Hankin • Dr. Justin J Verrone • Dr. Benjamin P Peters
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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

Patient Phone Number: _____

City/State/Zip Code: _____

I authorize Dr. Hankin/Verrone/Peters to **release information** to:

I authorize Dr. Hankin/Verrone/Peters to **obtain information** from:

 Name of Provider or Facility

 Name of Provider or Facility

 Address

 Address

 City/State/Zip Code

 City/State/Zip Code

 Phone Number/Fax Number (include area code)

 Phone Number/Fax Number (include area code)

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

Prescription: Spectacle Contact Lens

Medical Records (specify): _____

This consent will expire one (1) year from date of signature:

 Signature of Patient

 Today's Date

 Signature of Parent or Guardian

 Today's Date