AUTHORIZATION
FOR RELEASE OF MEDICAL RECORDS

I, ____, ____________________
Patient's Name (print) Date of Birth

____
Address

hereby request and authorize ________________________________
to release to **Jeff LaFerla Vision Institute** records of the last two eye examinations rendered to me including contact lens information (when applicable).

X________________________________ ____________________
Signature of Patient Date

X________________________________ ____________________
If the patient is a minor
Signature of the Parent/Legal Guardian Date

This authorization expires six months from the date of signature.
A photocopy of the authorization shall be valid as the orginal.

Jeff LaFerla, OD FAAO

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