MEDICAL RECORDS
RELEASE AUTHORIZATION

To: _____

_____

_____

_____

I hereby authorize & request you to release all examination records (including contact lens information and diagnostic testing) to:

1140 White Horse Road
Suite 1
Voorhees, NJ 08043

Phone: 856.784.3366
Fax: 856.784.4388
Email: office@eye-physicians.com

Signature:_____

Printed Name:_____

Date of Birth:_____

Social Security#:_____