MICHAELS EYECARE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO:____

I, ____, hereby authorize and request you to release medical information for:

First Name: _________________________ Last Name: ___________________________

Birth Date: ________________________

To
LaDota Optometry, PC
c/o Michaels Eyecare, Inc.
555 Delaware Street
Tonawanda, NY 14150
Ph: (716) 695-2024 Fx: (716) 389-3514

□ The complete history records in your possession, concerning my illness and/or treatment during the period from ___________________ to ______________________

□ ALL Records

Signed: ____ Date: ______________

Relationship to Patient:____

Witness: ____ Date: ______________