CAROLINA OPTOMETRIC

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RELEASE OF VISION RECORDS

TO: _____
PREVIOUS OPTOMETRIST/ OFFICE

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____

FAX: _____

This request represents my consent to release my medical records to the office listed above.

PATIENT'S NAME: _____ DOB: _____

SIGNATURE: _____ DATE: _____20____