RECORD RELEASE AUTHORIZATION

To:_____
Doctor or Hospital

_____
Address

I hereby authorize and request you to release to:

Family Vision Center
P.O. Box 826
Cedarburg, WI 53012-0826
(262) 377-3937
Fax 262-377-3948

the complete history records in your possession including:

[ ] All treatment provided during the period from _____to _____.

[ ] All contact lens information, parameters, and prescription.

[ ] All spectacle information including lens material and prescription.

[ ] Other:_____

Name:_____ DOB_____

Address_____

Signature_____Date_____
(If relative, state relationship)