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RELEASE OF MEDICAL RECORDS

Patient name:

First: _____ MI: ____ Last: _____
(please print)

Patient date of birth:_____

Address: _____

City:_____State:_____Zip: _____

I authorize_____
to release a copy of my medical records. This record includes, but not limited to any diagnosis, treatment, prognosis/recommendations and other pertinent data.

Release to:

Progressive Eye Care
3100 Ogden Ave.
Lisle, IL 60532

Patient/parent or guardian signature:_____

Date:_____