PATIENT RECORDS RELEASE

Patient Name: _____

Patient Address: _____

_____

Patient Birth Date: _____

TO:

Upon presentation of this authorization or a reproduction thereof, I hereby authorize and direct you to release my complete records, including any spectacle and contact lens prescriptions in your possession to:

Drs. Stuart and Marcia Glass
1001 SW 2nd Avenue #4000
Boca Raton, Florida 33432
Tel. # (561) 391-2362
Fax # (561) 391-3012

Patient's Signature _____ Date: _____

Witness: _____ Relationship: _____