Alameda Vision Center
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RECORDS RELEASE AUTHORIZATION

TO: _____

ADDRESS: _____

_____

PHONE: _____ FAX: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

I hereby authorize you to transfer a copy of my records to Alameda Vision Center. Thank you for your timely consideration of this matter.

PATIENT SIGNATURE: _____

PARENT OR GUARDIAN SIGNATURE: _____

DATE: _____