Lakes Area Eyecare

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AUTHORIZATION FOR RELEASE OF INFORMATION

RE: _____ DOB: _____

I authorize: _____

(Name of Facility)

to release to Lakes Area Eyecare information from the medical record including exams, OCT, Visual Fields and any other specialized tests while I was a patient at your facility. I understand that I may revoke this authorization at any time and without an express revocation. It will expire after one year from the date of signature.

_____ _____

Date Signature of Patient, Parent or Guardian

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