

RECORDS REQUEST

I hereby authorize: _____

**Doctor/Clinic Name/Hospital/Other*

Address

**Fax*

Phone

To release any information contained in my (or my child's) record:

PATIENT INFORMATION

**Name:* _____

Please Print

**Address*

**DOB*

**Phone*

**Signature*

**Date*

**Relationship to patient*

**Required Information*

To: MURRAY SCHOLLS VISION CENTER

Dr. Bradley Smith, OD
Dr. Keely Hoban, OD, FAAO
Dr. Michael Connell, OD
Dr. Emily Bee, OD

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Confidentiality note:

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