Jenkins Vision Care

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Medical Information Release

I hereby grant permission to Dr._____ and his/her staff to release all or parts of my private medical records, including case history, results of examination, diagnoses, treatment, etc., to the practitioner noted below.

_____

Patient Signature Date Patient Name (Printed)

Please note that medical information from your record will only be released to another physician.

Authorized information will be sent to :

Doctor's Name:_____

Address:_____