FIRST GLANCE Vision

# Eye Exam Records Release Form

Patient Name(s): _____

Date of Birth(s): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____

## Send Records to:

Name: _____

Send by: Postal Mail Fax Secure Email ***(Circle one)***

Address:_____

City: _____ State:_____Zip Code:_____

Email address: _____

Fax number:_____

I, _____***(Name)***,hereby grant permission for First Glance Vision to release confidential health information about me/child.

_____ _____

Printed Name Date

_____

Signature