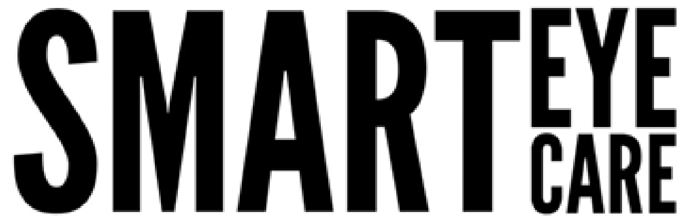

Medical Records Release Authorization

I authorize release of medical records:

From: ____________________________ ____________________________ ____________________________

To: ____________________________ ____________________________ ____________________________

For patient (print name): ____

DOB: _____/______/_____

Previous or Maiden Name (if applicable): ____________________

Approximate Date of Service: ______________________________

Please Circle Items You are Requesting:

Previous Exam Records Contact Lens Records Specialty Testing

Other: ____________________

Authorized Signature: ____

Date: _____________

255 Western Ave
Augusta, ME 04330
P: 207-622-5800
Fax: (207) 621-2790

824 Stillwater Ave
Bangor, ME 04401
P: 207-947-7554
Fax: (207) 945-0085

484 Maine Ave, Suite 1
Farmingdale, ME 04344
P: 207-582-5800
Fax: (207) 588-0743

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