MEDICAL RECORDS RELEASE AUTHORIZATION:

I authorize release of medical records

From: ________________________________ **To:** ________________________________

________________________________ ________________________________

________________________________ ________________________________

For Patient (print name): ____

(DOB): _______/_______/_______

Previous or Maiden Name: ____

Approximate Dates of Service: ____

PLEASE CIRCLE:

Previous Exam Records Contact Lens Records

Specialty Tests

Other: ________________________________

Authorized Signature: ____

Date: ______/______/______

255 WESTERN AVE.
AUGUSTA, MAINE 04330
TELEPHONE (207) 622-5800
1-800-459-5800
FAX (207) 621-2790

824 STILLWATER AVE.
BANGOR, MAINE 04401
TELEPHONE (207) 947-7554
1-877-427-1291
FAX (207) 945-0085

210 MAINE AVE.
FARMINGDALE, MAINE 04344
TELEPHONE (207) 582-5800
1-877-860-5800
FAX (207) 588-0743

WEBSITE: www.smarteyecare.com