

MEDICAL RECORDS
RELEASE AUTHORIZATION

To: _____

**I hereby authorize & request you to release all examination records
(including contact lens information and diagnostic testing) to:**



*1140 White Horse Road
Suite 1
Voorhees, NJ 08043*

*Phone: 856.784.3366
Fax: 856.784.4388
Email: office@eye-physicians.com*

Signature: _____

Printed Name: _____

Date of Birth: _____

Social Security#: _____