EYEDENTITY EYE CARE, LLC
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AUTHORIZATION OF RELEASE

FROM EYEDENTITY EYE CARE

I, _____ , authorize my doctor

Dr. Laura J. Holt Maloney, O.D., to release a copy of my records and/or prescription to the following:

DOCTOR NAME: _____

OPTICAL NAME: _____

ADDRESS: _____

ADDRESS: _____

PHONE: _____

FAX: _____

COMMENTS:

_____

PATIENT NAME

_____ _____

PATIENT SIGNATURE **DATE**