Advanced Eye Care
A Healthy Focus

Medical Release Consent

I _____ _____ do authorize _____
(patients name) (doctor's office)

Telephone Number: _____

Fax Number: _____

To release my medical information to _____ Advanced Eye Care _____
(parent/guardian name or medical facility)

Advanced Eye Care

Telephone Number: 205-942-7740

Fax Number: 205-942-7940

Signature_____

Name_____

Date of Birth_____

Date_____

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