Hunter's Hill Eyecare Center

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Lisa K. DeMers, O.D.
Matthew C. Smith, O.D.
Courtney M. Smyser, O.D.
Jessica A. Kaminsky, O.D.

PATIENT AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize you to release me, at the above address, any information, including the ocular and refractive diagnosis, pertinent findings, and records of any treatment from this patient's most recent visit(s) to your office. Thank you for your prompt attention to this request.

Patient Name: ____ Date: ______________
(PLEASE PRINT)

Patient Signature: ____ Date: ______________
(PARENT OR LEGAL GUARDIAN IF PATIENT IS A MINOR)

Patients Date of Birth: ____

Witness: ____ Date: ______________

Sincerely,

Lisa K. DeMers, O.D.
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Matthew C. Smith, O.D.
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