

Record Release Authorization

Date _____

To: _____

Address _____

I hereby authorize and request you to release my medical records to:

Clompus, Reto & Halscheid Vision Associates, P.C.
1450 E. Boot Road, Bldg. 700B
West Chester, PA 19380
Fax: 610-430-2079

Patient's Name: _____

Date of Birth: _____

Signature: _____

(Patient or Legal Guardian)

Witness: _____