CHAMPION EYECARE

6817 SOUTHPOINT PKWY, STE 1503, JACKSONVILLE FL 32216

INFO@CHAMPIONEYECARE.COM

904 903 4068

MEDICAL RECORDS RELEASE FORM

RE: _____

DOB: _____

I hereby authorize Champion Eyecare to request patient information from:

Name: _____

Address: _____

Zip Code _____

Information to be released:

_____

_____

_____

PLEASE FAX TO CHAMPION EYECARE 904 900 5347

This authorization is subject to my written cancellation at any time.

_____

Signature of Patient/Guardian

Date: _____