

Steve Edwards O.D. | Hunter Edwards O.D. | Taylor Edwards O.D.

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Records Release Form

Patient Name	
Date of Birth	
Address	
Phone Number	
I hereby authorize and request all of my reco	ords to be released to/from:
Name of Location	
Address	
Phone Number	
Fax	
Records to be released	
Patient Signature	Date
If you are signing as a personal representativ your relationship	e of the patient, please indicate
Representative	Relationship to patient