Patient Name(s)	Patient Date of Birth(s)

I do hereby request and give permission to release my Medical Records.

____ Glasses Prescription
____ Contact Lens Prescription
____ Diagnostic Testing (photos, OCT)
____ All Records

From the Office of:

Name: ________________________________
Address (1): ________________________________
Address (2): ________________________________
City/State/Zip: ________________________________
Office Phone: ________________________________
Office Fax: ________________________________

To the Office of:

Hunter Chapman, OD
Dillingham Chapman Family Eyecare
3805 Cypress St.
West Monroe, LA 71291
Phone: 318-387-4388
Fax: 318-387-4343

I understand that I have the right to revoke this authorization at any time by contacting this office with a verbal statement of revocation followed by written notice.

________________________________ ______________
Patient/Legal Guardian Signature *Date*