Sun Valley Eye Care

1901 W Warner Road, Suite 1
Chandler, AZ 85224
480-812-2010
480-812-1884

Authorization to Release Records

Date: ________________

Patient Name: ____

Date of Birth: ___________________________________

I give authorization to ____ to release my records to Sun Valley Eye Care.

I am authorizing the release of:

a. Spectacle prescription
b. Contact lens prescription
c. Last exam records
d. Complete record

Signature: ____

Date: ________________

Patient name:____

I give authorization to Sun Valley Eye Care to release my records to

____.

I am authorizing the release of:

a. Spectacle prescription
b. Contact lens prescription
c. Last exam record
d. Complete record

Signature: ____