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**AUTHORIZATION FOR RELEASE OF RECORDS**

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I, \_\_\_\_\_, hereby authorize the release of my records to  
In Focus Optometry, Inc.

Patient Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_

**Additional Patients:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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If you are signing as a personal representative of the patient, please describe  
your relationship to the patient.

Relationship to Patient \_\_\_\_\_  
Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

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