Low Vision Services, PLC
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Authorization to Release Confidential Information

Name of Patient:

Date of Birth:

Please could you send any vision/health-related information regarding this patient by fax or secure email above to 703-687-1744.

These records will be protected to the best of our ability and not shared with any other parties except where authorization has been granted in writing.

Duly authorized by

Patient or Power of Attorney Signature:

Printed name of Patient or Power of Attorney:

Date: