Dr. Bruce R Hankin • Dr. Justin J Verrone • Dr. Benjamin P Peters
2160 Penfield Road
Suite 100
Penfield, NY 14526
(585) 377-7090
(585) 377-3155 (fax)

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name:___________________________________

Patient Date of Birth: ______________________________

Patient Address: _________________________________

Patient Phone Number: ____________________________

City/State/Zip Code: ______________________________

I authorize Dr. Hankin/Verrone/Peters to **release information** to:

____
Name of Provider or Facility

____
Address

____
City/State/Zip Code

____
Phone Number/Fax Number (include area code)

I authorize Dr. Hankin/Verrone/Peters to **obtain information** from:

____
Name of Provider or Facility

____
Address

____
City/State/Zip Code

____
Phone Number/Fax Number (include area code)

TYPE OF RECORDS REQUESTED: (circle appropriate item[s])

Prescription: Spectacle Contact Lens

Medical Records (specify): ____

This consent will expire one (1) year from date of signature:

____
Signature of Patient

____
Today's Date

____
Signature of Parent or Guardian

____
Today's Date