IMAGINE
OPTOMETRY

3860 Fallon Road
Dublin, CA 94568
email: info@imagineoptometry.com

Authorization for Request of Health Information

To: _____

_____

_____

Dear _____:

I am authorizing and requesting that you release all health record information pertaining to the below named patient.

Patient Name:_____ **Date of Birth:**_____

Please release the health record information to:

IMAGINE Optometry
3860 Fallon Road
Dublin, CA 94568
Email: info@imagineoptometry.com

Sincerely,

_____ _____
Signature Date

_____
Print Name (Relationship: ☐ Self ☐ Parent ☐ Guardian)