SURE VISION Eye Centers

AUTHORITY TO RELEASE MEDICAL RECORDS

You are hereby authorized to furnish and release all information and records requested concerning findings, treatment and opinions as to my condition **TO: SUREVISION EYE CENTERS MIDWEST**

Doctor or Hospital_____

Address _____

_____

Telephone _____FAX _____

RE: Patient Name _____

Date of Birth _____

Social Security Number _____

_____
Patient Signature

_____
Witness Signature

_____
Date

SureVision Eye Centers Midwest
7934 North Lindbergh Boulevard
Hazelwood, MO 63042
(314) 921-2020
(314) 838-9536 FAX