HOMETOWN
EYE CARE

MEDICAL RECORDS

RELEASE AUTHORIZATION

PATIENT INFORMATION	
PATIENTS NAME	
ADDRESS	
DATE OF BIRTH	
PHONE	
PERSON REQUESTING RECORDS & RELATIONSHIP	

REQUESTING MY PRIOR EYE CARE MEDICAL RECORDS FROM –	
PRIOR OPTOMETRISTS NAME	
ADDRESS	
PHONE	
FAX	
☐	I HEREBY AUTHORIZE AND REQUEST THAT [DOCTORS NAME LISTED ABOVE] TRANSFER MY COMPLETE MEDICAL RECORDS OR OTHER HEALTH CARE INFORMATION CONCERNING MY PAST HEALTH & TREATMENT TO: **HOMETOWNE EYE CARE PLLC. 17 BOYNTON LANE, LITTLETON NH 03561** **PHONE 603-259-1400 / FAX 603-259-1403**

REQUESTING MY HOMETOWN EYE CARE MEDICAL RECORDS BE SENT TO –	
DOCTORS NAME	
ADDRESS	
PHONE	
FAX	
☐	I HEREBY AUTHORIZE AND REQUEST THAT HOMETOWN EYE CARE, PLLC TRANSFERS MY COMPLETE MEDICAL RECORDS IN THEIR POSSESSION OR OTHER HEALTH CARE INFORMATION CONCERNING MY HEALTH AND TREATMENT.

PATIENT'S SIGNATURE (OR GUARDIAN)	DATE