ADVANCED VISION CARE

Authorization for Use and Disclosure of Health Personal Information

Advanced Vision Care Optometry
14140 Meridian Parkway Suite 101
Riverside, CA 92518
Phone 951-243-3337, Fax (951) 243-6868
Email: reception@avceyecare.net

Date: _____

Patient's Name: _____

Medical Record# (if applicable): _____

Patient's Date of Birth: _____

Please release my exam records/ spectacle rx/ contact lens rx to:

To Facility/Doctor:_____

_____

_____

_____

Phone_____Fax_____

Email_____

Patient's Signature _____

Legal Representative _____