ADVANCED VISION CARE

Authorization for Use and Disclosure of Health Personal Information

Date: _____

Patient's Name: _____
Medical Record# (if applicable): _____
Patient's Date of Birth: _____

To Facility/Doctor:_____

_____

_____

_____

Phone_____Fax_____
Email_____

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

Advanced Vision Care Optometry
14140 Meridian Parkway Suite 101
Riverside, CA 92518

Phone 951-243-3337
Fax (951) 243-6868
Email: reception@avceyecare.net

If you have any questions, please do not hesitate to call (951) 243-3337.

Patient's Signature _____

Legal Representative _____