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Cincinnati EyeCare Team

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Authorization For Release of Vision/ Ocular Health Information From Cincinnati EyeCare Team

I hereby give my permission to Cincinnati EyeCare Team to release the following confidential information: (Check all that apply)

- Eyeglass Prescription
- Contact Lens Prescription
- Entire Patient Record

Today's Date: _____

Patient Name: (Print) _____

Patient Signature: _____

Date of Birth: _____

PLEASE FORWARD INFORMATION TO THE FOLLOWING ADDRESS:

FAX #: (_____) _____

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 8629 N. Pavilion Dr.
 West Chester, OH 45069
 (513) 860-0400
 fax (513) 942-5321

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 Cincinnati, OH 45220
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