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Authorization To Release Vision/ Ocular Health Information To Cincinnati EyeCare Team

Date: _____

Patient Name: (Print) _____

Patient Signature: _____

Date of Birth: _____

Patient Address: _____

Street

City & State

Zip Code

Patient's Phone #: (____) _____

PLEASE RELEASE THE FOLLOWING INFORMATION TO CINCINNATI EYECARE TEAM: (Check all that apply)

Eyeglass Prescription

Contact Lens Prescription

Entire Patient Record

SEND TO CINCINNATI EYECARE TEAM AT:

Clifton Office Fax (513) 872-2122

Union Centre Office Fax (513) 942-5321

We appreciate your assistance in providing continuity of vision care for the above patient.

Sincerely,
Cincinnati EyeCare Team

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

Clifton
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Cincinnati, OH 45220
(513) 872-2028
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