CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _____

Address: _____

Phone: _____

I hereby authorize iDoc Optical to release this information to: _____

Address: _____

The following medical, or optical information on the above patient(s):

☐ Glasses RX ☐ Contact Lens RX

☐ Examination Notes ☐ All Patient Information

X_____ _____ _____

Signature of patient (parent/guardian if minor) Print Name Date