



MICHAELS EYECARE

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: _____

I, _____, hereby authorize and request you to release medical information for:

First Name: _____ Last Name: _____

Birth Date: _____

To
LaDota Optometry, PC
c/o Michaels Eyecare, Inc.
363 Delaware Street
Tonawanda, NY 14150
Ph: (716) 695-2024 Fx: (716) 389-3514

- The complete history records in your possession, concerning my illness and/or treatment during the period from _____ to _____
- ALL Records

Signed: _____ Date: _____

Relationship to Patient: _____

Witness: _____ Date: _____