Oculare
PERSONALIZED EYECARE
BY DR. GAVIN COHEN

Date: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize the release my protected health information (PHI) as described below:

Patient Name: _____

Date of Birth: _____

Records to be Released (check all that apply):

- ☐ Complete Medical Record
- ☐ Examination Notes
- ☐ Contact Lens Prescription and/or WAVE files
- ☐ Spectacle Prescription
- ☐ Diagnostic Testing (OCT, Optos, Visual Fields, etc.)
- ☐ Other: _____

Release Records To:

OCULARE PERSONALIZED EYECARE

Patient/Legal Representative Signature: _____

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