

# Dilworth Eye Associates

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TO: \_\_\_\_\_, \_\_\_\_\_  
(DOCTOR'S NAME) (OFFICE LOCATION)

I hereby authorize and request the release of my medical records and any additional information that could be helpful in future evaluations.

DATE: \_\_\_\_\_ DOB: \_\_\_\_\_

NAME (PRINT): \_\_\_\_\_

SIGNATURE: \_\_\_\_\_