Dr. Adriana Wiseman, O.D, P.C

Mobile Eye Care

RECORDS RELEASE

DATE ________________________

TO____

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I hereby authorize you to release to Dr Adriana Wiseman, New Vision Optometry any information including diagnosis and records of any treatment or examination rendered to me during my entire course of treatment and visits.

NAME (please print)

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DATE OF BIRTH

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SIGNATURE

____

ADDRESS / TELEPHONE/ CONTACT

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Tel 240-203-9333 Fax 240-319-7376 Email Desk@NewVisionOptometry.com