Snodgrass Family Eyecare

1250 NW 128th Street, Suite 150

Clive, Iowa 50325

Phone (515)223-9595

Fax (515)223-9792

RECORDS REQUEST

By signing this form I am giving permission for: _____

(Office Name)

_____

(Address) (City) (State & Zip)

to release the following information to Snodgrass Family Eyecare .

____contact lens prescription

____eyeglass prescription

____all patient records

____most recent exam

Check the reason for the request of information.

____ Moved ____ Transferring care ____ Purchasing hardware ____ Insurance ____ Coordinating Care ___Other

This authorization is voluntary. It will expire one year from the signature date. I have the right to cancel this consent at a later date (in writing either faxed or mailed to the above), however I understand that my information may have already been released.

Print Name: _____

Signature: _____ Date of birth: _____

Relationship if not the patient: _____Date:_____