COASTAL VISION CENTER

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AUTHORIZATION FOR RELEASE OF PATIENT RECORDS

□ **Release to Coastal Vision Center**
I hereby authorize the release of my medical records and any applicable prescription information to Coastal Vision Center from:

Name of Doctor: _____

Phone: _____ Fax: _____

□ **Release from Coastal Vision Center**
I hereby authorize Coastal Vision Center to release my medical records and any applicable prescription information to:

Name of Doctor: _____

Phone: _____ Fax: _____

□ **Email retinal exam images**
I hereby authorize Coastal Vision Center to email my Optomap Ultra-Widefield Retinal Images to the following email:

Email: _____

- **Patient Name:** _____
- **Date of Birth:** _____ **Last 4 SSN:** _____
- **Signature:** _____ **Date:** _____