Woldorff Family Optometry, PA
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Authorization to Release Medical Records

By signing below, I,

authorize

located at

and phone number

to release to **Woldorff Family Optometry, PA,**

the medical records for

myself

my dependent(s)

Name(s) of dependent(s) and date(s) of birth

Signature ____ Date

Relationship to patient if signed by guardian or representative