Record Release Authorization

To: ____
(Doctor or Hospital)

Address: ____

____

____

I hereby authorize and request you to release my records to:

Concord Family Vision, PLLC
8 North State Street
Concord, NH 03301
Phone 603 225 2512 Fax 603 225 3249

Name: ______________________ **DOB:** ____/____/____
(please print)

Address: ____

____

Patient
Signature: ______________________ **Date:** ____/____/____

Doctors of Optometry

Christopher P. Udina, OD ♦ Abbie Martin, OD ♦ Kelly Schoorens, OD ♦ Charles Daniels III, OD