BIG CITY
OPTICAL

I hereby authorize that my medical records be released to:

DOCTOR'S/OFFICE'S NAME: _____

OFFICE PHONE NUMBER: _____

OFFICE FAX NUMBER: _____

PATIENT NAME: _____

PATIENT DOB: _____

PATIENT ADDRESS: _____

PATIENT PHONE NUMBER: _____

PATIENT SIGNATURE: _____ DATE: _____

PLEASE FAX REQUESTED INFORMATION BACK TO: _____