RECORDS RELEASE FORM

I, _____, authorize the release of my records from Holt Eye Care PLLC. This information will be used solely for the purpose of providing appropriate and efficient health care.

_____ _____

SIGNATURE **DATE**

_____ _____

PATIENT D.O.B. **RECORDS GOING TO**

HOLT EYE CARE
DRAPER EYEWEAR

(517) 699-3937

Holt Eye Care
2040 N Aurelius Rd Suite 20, Holt, MI 48842
F (517) 699-4199

Draper Downtown
300 S. Washington Sq. Suite M20 Lansing, MI 48933
F (517) 485-9053

Draper Greenlawn
405 W. Greenlawn St. Suite 101 Lansing, MI 48933
F (517) 482-1324