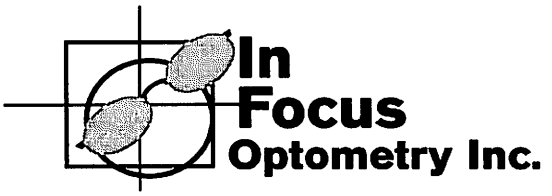

AUTHORIZATION FOR RELEASE OF RECORDS

I, _____, hereby authorize the release of my records to In Focus Optometry, Inc.

Patient Name _____
Date of Birth _____
Address _____
Phone Number _____

Additional Patients:

Name _____ Date of Birth _____
Name _____ Date of Birth _____

Signature _____ Date _____

If you are signing as a personal representative of the patient, please describe your relationship to the patient.

Relationship to Patient _____
Print Name _____

Signature _____ Date _____

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