Release of Information
(Informed Consent)

I, _____ _____ DOB ____/_____/_____
(Patient First Name) (Last Name)

Address:

Street City State Zip

_____ _____ Authorize _____ _____**to**
(Phone) (Sex) (Dr.'s Name or Practice Name)

disclose information (as described below) from my health care record to:

☐ Custom Eyes, LLC 175 N. Stephanie # 130 Henderson NV. 89074
FAX 702-564-7552 Phone 702-5643678

Please fax my most recent :

- ☐ Eye glass Prescription
- ☐ Contacts lens prescription
- ☐ Both eyeglass and contact lens prescription
- ☐ Other: _____

_____ **X**_____
(Date of Signature) (Signature of Patient)

_____ **X**_____
(Date of Signature) (Person Authorized by Patient/ Relationship)