Vision Plus of Ballard

Dr. Mark Pyle
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Authorization to Send Records

I, ______________________________________ (please print name), authorize Vision Plus of Ballard to send my records to the following entity/office:

Name of outside provider/office:
Attention to:
Office address:
Fax number:
Phone number:

- ☐ Eye health records only
- ☐ Spectacle and contact lens prescription only
- ☐ Spectacle and contact lens prescription, and eye health records
- ☐ All existing medical records

______________________________	______________________________
Patient Name (Printed)	Patient Date of Birth
______________________________	______________________________
Patient Signature	Date