RECORDS RELEASE REQUEST

To ____

(Doctor/Hospital)

Address ____

City ______________________________________ State _______ Zip ____________

I hereby authorize the release of my _____________________________________

__________________________________ or copies of such and request that they be transferred to:

Dr. John Mark Bickerton

West Point Vision Care

3180 King William Ave

West Point, VA 23181

Ph. 804-843-9030, Fax 804-843-9031

____

Print Name of Patient

From: ______________________________ To: _______________________________

(Date of Records)

____

Patient's Signature **Date**