Tozer Eye Center

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Kevin M. Huff, O.D.
Optometrist

Medical Records Release Form

From: Physicians Name____

Address____

City____________________________State________Zip__________________

Telephone____________________________Fax____________________________

I hereby request that my medical records be released to:

To: Physicians Name____

Address____

City____________________________State________Zip__________________

Telephone____________________________Fax____________________________

Please Print Name____________________________ Date of Birth__________________

Patient/Guardian Signature____________________________ Date__________________

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