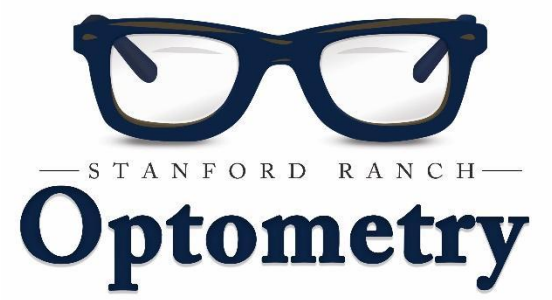

Authorization for Release of Medical Records

Date: _____

Patient Name: _____

Patient D.O.B: _____

I Authorize Release of information from:

Name of Practice: _____

Phone: _____ Fax: _____

I Authorize the Release of information to:

Stanford Ranch Optometry

2351 Sunset Blvd. #190 Rocklin, CA, 95765

Phone # (916) 624-9396 Fax # (916) 624-9215

Information to be Disclosed:

____ Please release a copy of ALL my Medical Records.

____ Please release a copy of my Spectacle/ Contact Lens RX.

____ Other: _____

Signature of Patient or Legal Representative/Guardian:

Signature: _____ Date: _____