N. Timothy Peters, MD
Medical Director / Surgeon

Jennifer Ling, MD
Ophthalmologist / Surgeon

Christopher Turner, OD
Optometrist

Lauren McLoughlin, OD
Optometrist

Dwight Arvidson, OD
Optometrist

RECORDS RELEASE

Name: _____DOB:_____

I hereby authorize and request the release of my complete medical records in your possession concerning my illness and/or treatment from:

_____

Doctor and / or Office Name

_____

Address

_____

City / State / Zip

_____

Phone **Fax**

These records are for a refractive surgery evaluation. We would appreciate the last two (2) eye exams including refractions.

To

CLEAR ADVANTAGE VISION CORRECTION CENTER
155 Borthwick Avenue, Suite 200 East
Portsmouth, NH 03801
Phone: 603-501-5000
Fax: 603-501-5001

Signature_____Date_____