OLD TOWN Optical

Old Town Optical
Records Release Authorization

Patient Name: _____

Date of Birth: _____

Address: _____

_____

I, _____,

hereby authorize you, _____

Located at: _____

Fax number: _____

to release my medical records to: Dr. Nathan Baas

Located at: 515 South Union Street, Traverse City, MI 49684

Fax number: 231.946.1665

_____ Please include all office notes currently on file

_____ Please include last progress note and contact lens information

_____ Please include specific records of: _____

Authorizing signature: _____Date: _____

Witness signature: _____Date: _____