Visual expressions

Records Transfer Request

Date : _____

To : _____

Street Address : _____

City : _____ State : _____ ZIP : _____

Phone : _____

I hereby authorize the release of my _____
or copies of such, and request that they be transferred to:

Visual Expressions Optometry

3580 Blackhawk Plaza Circle, Danville, CA 94506

Phone: (925) 648-9393 Fax: (925) 648-9394

_____ _____

Patient Name Signature (Patient, Parent, or Guardian)