SAINT OPTICAL
1518 W. Airline Hwy.
LaPlace, LA 70068
Phone# (985)652-4097
Fax# (985)652-9917

RECORD RELEASE

DATE_____

I , _____, hereby authorize the release of any information including the diagnosis and records of any treatment or examination rendered to me during the period from _____ to _____ at _____.

_____
Signature

_____
Print Name

_____
DOB

_____
Address