Dr. Aaron Hesla - Dr. Adrienne LeVasseur

Release of Eyecare Information Form

I, ______________________________, authorize the release of eye care information for the patient(s)

outlined below, to (Dr. Hesla / Dr. LeVasseur) at Hesla Optometry on __________________________.
(Insert Date of Request)

Authorizing Signature: ____________________________ **Phone #**: __________________________

Patient Name	DOB
_____________________________________	_________________________
_____________________________________	_________________________
_____________________________________	_________________________
_____________________________________	_________________________

- ☐ All Records on File
- ☐ Prescription
  - ☐ Ophthalmic
  - ☐ Contact Lens
- ☐ Full Eye Exam Information
- ☐ Photos and/or OCT's
- ☐ Visual Field Results
- ☐ Letters from Ophthalmologists or MD's

Note: This transmission, including attachments, is intended only for the named recipients above and may contain information that is privileged, confidential, and/or exempt from disclosure under applicable law. If you received this in error, please notify the sender immediately by calling 403-262-2958 and destroying this transmission. Thank you in advance.

P: 403-262-2958 F: 1-866-66HESLA (1-866-664-3752) E: hello@heslaoptometry.com