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Doctors of Optometry
56 State Street
Pittsford, NY 14534
(585) 381-4640
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Date: _____

I hereby authorize:

_____

_____

_____

to release any and all copies of my medical records, including any lab reports, special tests, etc. to:

_____

56 State Street

Pittsford, NY 14534

Thank you,

_____
Signature

_____
Printed Name

_____
Witness