Dr. Mohan Poole, OD

Therapeutic Optometrist

Poole Eye Associates

Date:_____

To whom it may concern:

This authorizes_____to release a copy of my medical records to Dr. Mohan Poole. A copy of this release may act as an original.

Thank you,

_____

Signature Date of Birth

_____

Printed name

Poole Eye Associates

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