INNOVATIONS in EyeCare

Records Transfer Authorization

I would like to have copies of all my records pertaining to my eye examinations, glasses, and contact lens prescriptions transferred to Innovations in EyeCare, Inc. with Dr. Dolezal and Dr. Cannon.

Previous Doctor Information

Doctor's Name: _____

Business Name: _____

Location: _____

Patient Information

Patient Name (please print): _____

Date of Birth (mm/dd/yyyy): _____

Social Security Number: _____

Responsible Party Information

Name of Responsible Party: _____

Relationship to Patient: _____

By my signature below I authorize the transfer of these records.

Signature: _____ Date (mm/dd/yyyy): _____

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