



Authorization for Release of Medication List For the Purpose of Continuity of Care

Primary Care Doctor: _____

Address: _____

Fax Number: _____

Patient Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____

The specific information I am requesting is my most updated MEDICATION list.
This information should be released to :

Focused Eye Care
505 West Hollis St. Suite 109
Nashua, NH 03062
Phone (603) 882-0311
Fax (603) 882-3020

I understand that I may revoke this consent at any time, except where information has already been released. This authorization is valid for a sixty (60) day period from the date that it is signed.

Signature: _____ Date: _____

Patient (Parent/Legal Guardian if a Minor)

FEC-MRA-021023