DALLAS SERVICES

Dallas Day School **Low Vision Clinic** **Dallas Therapy Clinic**

RELEASE FORM

I, _____ authorize release of medical records from _____ to the Low Vision Clinic. I also understand that I may revoke this consent at any time except for action which was taken based on it. I further authorize that a photocopy of this authorization form be fully acceptable as an original.

_____ _____

Patient Name Date

_____ _____

Guardian/Parent (if appropriate) Date

www.dallasserivces.org

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