DR. STANLEY J. HALLOCK
OPTOMETRIST

5460 CURRY-FORD ROAD
ORLANDO, FLORIDA 32806
(407) 277-1140
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RECORD RELEASE AUTHORIZATION/INFORMATION FORM

TO: ______________________________

______________________________

______________________________

PATIENT NAME (print) ______________________ (maiden) ______________

SIGNATURE ______________________ ADDRESS ______________________

PARENT/GUARDIAN SIGNATURE ______________________

This is to authorize and request release of records, in their entirety, to Dr. Hallock.

Specifically, but not limited to:

Original K date ______ R ______ L ______ ALLERGIES ______________

RECENT K date ______ R ______ L ______ MEDICATIONS ______________

FUNDUS ______________________ DilatedYN, cup/disc R ______ L ______

CORNEA CONDITION R ______________________ L ______________________

ORIGINAL PRE-CONTACT REFRACTION (DATE) ______ R ______________ L ______________

MOST RECENT REFRACTION (date) ______ R ______________________ VA 20/

L ______________________ VA 20/

Has this patient ever had difficulty adapting spectacles/bifocals? Y N

IOP R ______ L ______ INSTRUMENT USED ______________

CL PARAMETERS (please list most recent pair here, others list on back)

| | Base curve | Power | Size / OZ | Perif. curves | CT | BRAND/POLYMER/MATER |
|---|---|---|---|---|---|---|
| R | | | / | | | |
| L | | | / | | | |

Other features: ______________________ Tint: ______________

Worn as: Daily wear, Extended wear