Eye Options, Inc.
2139 Cottman Avenue
Philadelphia, PA 19149
P: 215-745-1444 ■ F: 215-745-1448

Methods of Prescription Release Authorization Form

Patient name (printed): _____ Date of birth: _____

Patient or guardian signature: _____ Date signed: _____

I hereby authorize Eye Options, Inc. to release my prescription records via the following methods (please check off and initial next to all that apply):

☐ Mail _____

☐ Fax _____

☐ Third party vendors (ex. 1-800-contacts, lens.com, etc.) _____

☐ In-person in our office _____

If you have elected for in-person release, please list any authorized parties other than yourself who can pick up your records on your behalf: _____

_____

_____