Dr. J. Mark Saunders
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Optometrist
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Shallotte, NC 28470

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Patient Name: _____ Date of Birth: _____

I hereby give permission to _____, to release all medical records to _____, including all diagnosis and treatments. This information will be used for continued care and/or treatments.

_____ _____
Patient Signature *Date*

If under 18, _____ _____
Guardian Signature *Relationship*

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