



**M O O R E**  
**EYE CLINIC**

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MEDICATION RELEASE REQUEST

In accordance with Meaningful Use Policy, I hereby authorize the release of my official medication list to Robert L. Moore, O.D.

Name of Patient: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_