Dr. Francis L Pinard, OD
& Associates
Newport Optical
124 East Main Street, Suite 1
Newport, Vermont 05855
Ph: (802)334-2772
Fax: (802)334-5667

Date _____

Request for Record Transfer

Name:_____DOB_____

Address:_____
_____

- I hereby authorize and request that **you transfer to** Francis L. Pinard, OD & Associates and Newport Optical the complete medical records in your possession pertinent to my present or past ocular/medical condition.

- I hereby authorize and request that Francis L. Pinard, OD, & Associates and Newport Optical, **transfer to you** the complete medical records in their possession pertinent to my present or past ocular/medical conditions.

To: Doctor_____
Address_____
_____
Fax _____

Signature:_____Date_____
Witness:_____