Kevin B. Wynne O.D. PLLC
56 State Street
Pittsford, N.Y. 14534
(585) 381-4640
(585) 381-3322 fax

Date: ____________

I hereby authorize:

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to release a copy of my medical records, including any lab reports, special test results, etc. via fax/mail to:

Kevin B. Wynne O.D.
56 State Street
Pittsford, N.Y. 14534

Thank you,

____
Signature

____
Printed Name

____
Witness