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Optometric Physicians

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3293 N Milwaukee St
Boise, ID 83704-4445
(208) 322-2020



Date: _____

Patient Records Release from Boise Vision Care

I, _____, DOB: _____, hereby authorize the release of my visual
(please print name)
examination records from Boise Vision Care, P.A., Dr Boespflug or Dr Cleverly. Please also include any
medical findings as well as fitting information on contact lenses. The fax number at Boise Vision Care is
208-322-1192, and the email address is care@boisevisioncare.com. If you have any questions, you can
contact me at () _____.

Patient or Guardian's Signature

Please send the information to: _____

Phone #: _____

Fax #: _____

E-mail: _____