Stanford HEALTH CARE

ADDRESSOGRAPH - PATIENT NAME, MEDICAL RECORD NUMBER

Contact Lens Prescription

I, ____________________ , confirm that I have received a copy of my contact lens prescription.
(Patient name)

DATE TIME SIGNATURE (Patient /Legal Designated Representative)

PRINT NAME RELATIONSHIP TO PATIENT

DATE TIME PHYSICIAN SIGNATURE PRINT NAME

Complete this section if patient refuses to sign above:

☐ The patient, ____________________, has refused to sign that they received a copy of their
(Patient name)
contact lens prescription.

DATE TIME STAFF SIGNATURE PRINT NAME

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