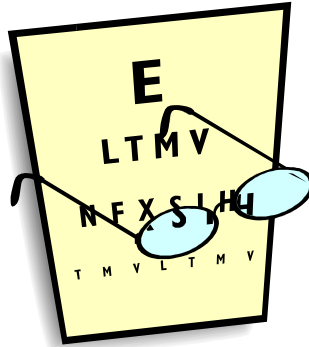


HOPKINTON VISION CENTER FAX

Dr. Steven Perryman
Optometrist
10 Cedar St
Hopkinton, MA 01748
508-435-4711
(fax) 508-435-5053



FROM: Dr. Steven Perryman OD

TO: _____

DATE: _____

SUBJECT: _____

I would like to request that my medical records be transferred to Hopkinton Vision Center, either through fax at the above fax number, or mailed to the above address.

NAME _____

DOB _____

Signature: _____