Authorization to Release Medical Records

Please send the following upon receipt:

- Complete Record
- Last visit
- Eyeglass prescription
- Contact Lens prescription
- Vision Therapy records
- Results of Consultation / Work-up

For: ____ DOB: _____________

Address: ____

I ____, authorize

Dr. ____ at

Fax ___________________

to release the above records

To: Elemental Eyecare

2736 NW Crossing Dr. Suite 120

Bend OR 97701

P – 541-323-3937

F – 541-323-3938

Email – info@elementaleyecare.com

____ ____________________

Signature Date

elemental

EYECARE