EYECARE ASSOCIATES

RECORDS RELEASE AUTHORIZATION (TO ECA)

Date:_____

To: _____

Fax #:_____

I hereby authorize and request you to release to Eyecare Associates of Southern Oregon

- o The complete medical records/history in your possession
- o The most recent spectacle prescription
- o The most recent contact lens prescription

Patient Name: _____ DOB: _____

Signed: _____

(Patient or Legal Guardian)

Please transmit via

- o Fax - 541-779-8778
- o Mail - 935 Royal Ave, Medford, OR 97504

Brian Mitchell, OD | Tessa Johnston, OD | Damon Hanson, OD

935 Royal Avenue, Medford, Oregon 97504 | Phone 541-779-2211 | Fax 541-779-8778 | www.EyeCareSouthernOregon.com