EYECARE ASSOCIATES

Records Release Authorization (To ECA)

Date: _____

To: _____

Fax#: _____

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

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

Patient Name: _____ DOB: _____

Signed: _____

(Patient or Legal Guardian)

Please transmit via

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

Brian Mitchell, OD | Tessa Johnston, OD | Damon Hanson, OD
935 Royal Ave Medford, Oregon 97504 | Phone 541-779-2211 | Fax 541-779-8778 | www. EyeCareSouthernOregon.com