EYECARE ASSOCIATES
OF SOUTHERN OREGON, P.C.

RECORDS RELEASE AUTHORIZATION

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 K. Mitchell, O.D. **Tessa C. Johnston, O.D.** **Kurt Wilkening, O.D.** **Damon Hanson, O.D.**

935 Royal Ave Medford, OR 97504 541-779-2211 www.ecaofmedford.com