RECORDS RELEASE REQUEST / AUTHORIZATION

Date: _____

Patient Name: _____

DOB: _____

Parent / Guardian if applicable: _____

I hereby authorize you to release my records:

□ ***FROM*** **Lifetime Vision Care, LLC**
901 NW Carlon Ave, Suite 2
Bend, OR 97703
Tel: (541) 382-3242
Fax: (541) 317-3579

-OR-

□ ***TO*** **Lifetime Vision Care, LLC**
901 NW Carlon Ave, Suite 2
Bend, OR 97703
Tel: (541) 382-3242
Fax: (541) 317-3579

□ Clinic/ Facility Name:_____

Attention:_____

Address:_____

_____

Phone:_____

Fax:_____

□ Other Notes:

_____

_____

Signature: X_____