LIFETIME vision care

RECORDS RELEASE REQUEST/ AUTHORIZATION

Date:____________________

Patient Name:____

Date of Birth:____

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
P: (541) 382-3242
F: (541) 317-3579

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

☐ **Clinic/Facility Name:**_____________________________________

Attention:____

Address:____

____

Phone:____

Fax:____

☐ **Other Notes:**____

____

Signature: X____