EYECARE ASSOCIATES
OF SOUTHERN OREGON, P.C.

RECORDS RELEASE AUTHORIZATION

Date:_____

I hereby authorize Eyecare Associates of Southern Oregon, P.C. to release medical records

concerning _____ _____ covering the period
(Patient) (DOB)

from _____ to _____, to:

Name: _____

Address: _____

_____

Signed: _____
(Patient or Legal Guardian)

Witness: _____

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

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