Authorization to Release Medical Records

Please send the following upon receipt:

- ☐ Complete Record
- ☐ Last visit
- ☐ Eyeglass prescription
- ☐ Contact Lens prescription
- ☐ Vision Therapy records
- ☐ Results of Consultation

Patient name: _____ Date of Birth:_____

Address: _____

City:_____ State:_____ Zip:_____

I _____, authorize _____,

at (fax) _____to release the above records to:

Sunflower Vision Care

301 E 2nd St

The Dalles, OR 97058

Phone: 541-370-1437

Fax: 877-541-1271

Email: info@sunflowervisioncare.com

_____ _____

Signature Date