1597 SW 53rd St. Corvallis, OR 97333

Ph: 541-757-8844 Fax: 541-754-9810

RECORD RELEASE FORM

Patient's Full Name: _____ DOB: _____

Print Name

I, _____ , authorize the release of the records listed below:

__ Eye Exam

___ Spectacle Prescription

___ Contact Lens History and Prescription

___ Additional Medical Records Including: _____

Release To: _____ Fax: _____

Release From: _____ Fax: _____

I have reviewed and I understand this authorization. I also understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under Federal Law.

Signature: _____ Date: _____

Relation : _____

You have the right to revoke this authorization at any time, provided that you do so in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, we cannot take back any uses or disclosures already made with your permission. To revoke this authorization please contact All Family Vision Care directly, identifying the date you signed this authorization, the recipient of the information identified in this authorization, and state that you are revoking this authorization. This authorization will expire 90 days from the date of signing, or the end of the period reasonably needed to complete the disclosure of the above-described purpose.