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Dr. Chris Swanson Dr. Timothy Snider Dr. Larry Silkey Dr. Shane Claborn

Authorization for Record Release from **ANOTHER** Office

I, ________________________, authorize the release of my medical records, including but not limited to my contact lens & glasses prescriptions, to Complete Eye Care.

_______________________________ ___________

Signature of Patient /Parent Date

OR

Authorization for Record Release from **OUR** Office

I, ________________________, authorize the release of my medical Records to the following: ____________________________.

I release Complete Eye Care from any liability associated with the misuse of my confidential medical information. I further release Complete Eye Care from any liability or neglect as a result of harm or injury related to the use or misuse of any products received as a result of this medical release.

_______________________________ ___________

Signature of Patient Date

Main Location: 1224 N. Sheridan Rd., Lawton, OK 73505 | Phone: 580-355-2020 | Fax: 580-248-0074
Downtown Location: 409 SW C Avenue, Lawton, OK 73501 | Phone: 580-248-5280 | Fax: 580-248-4500