RECORDS RELEASE AUTHORIZATION

TO: ____
(Doctor or Hospital)

____
(Address)

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

EYE CARE CENTER OF NEWTON
100 N 4TH AVE W
PO BOX 1007
NEWTON, IOWA 50208

PHONE# 641-792-7900
FAX# 641-792-8663

I WOULD LIKE MY ___ GLASSES PRESCRIPTION
___ CONTACT LENS PRESCRIPTION
___ COMPLETE EXAMINATION RECORDS
___ RECORDS FROM ______ TO ______

FAXED TO THE EYE CARE CENTER OF NEWTON AT (641) 792-8663.

NAME: ______________________________ DATE: ____________________

ADDRESS: ____

DOB: ______________

SIGNATURE: ______________________________
(IF RELATIVE, STATE RELATIONSHIP)

WITNESS: ______________________________