EYE DEPARTMENT

Eye Care & Eyewear

MEDICAL RECORDS RELEASE

Patient Name: _____ Date of Birth: _____

I authorize and hereby request that a copy of my medical records be released as follows:

Information to be Released:

- ☐ Eye Glasses Prescription
- ☐ Contact Lens Prescription
- ☐ Eye Health Records

Information to be Released From:

Physician:

Address:

Phone:

Fax:

Release Records To:
Dr. Annie Bacon
921 SW 16th AVE, Portland, OR 97205
Fax: 503-227-0509
hello@eyedepartment.com

The purpose of the request is for continued medical care.

_____ _____

Signature of Patient or Legal Guardian Date

EYE DEPARTMENT
Dr. Annie P. Bacon
P. 503.227.0573
F. 503.227.0509

921 SW 16th Ave.
Portland, OR 97205