Records From____
Name of doctor and facility

Address ____

City ____________________ State __________ Zip _________

Phone __________________ Fax ____________________

Records To ____
Name of doctor and facility

Address ____

City ____________________ State __________ Zip _________

Phone __________________ Fax ____________________

I hereby authorize the release of my:

□ spectacle prescription (for information purposes only)
□ contact lens prescription (for information purposes only
□ most recent examination
□ reports from other doctors
□ most recent medical/ocular history
□ records (all-inclusive; everything in my file)

__________________________________ DOB ____________
Patient name

__________________________________ Date ____________
Patient's Signature/Parent (if minor)

Morris Location
1802 N Division St, Ste 205 Morris, IL 60450
Phone (815) 942-3042
Fax (815) 942-3062

Spring Valley Location
200 W Dakota St, Spring Valley, IL 61362
Phone (815) 663-8281
Fax (815) 663-8190