COCKRELL EYECARE CENTER

DAVID A. COCKRELL, O.D., F.A.A.O
Family Optometry
Contact Lenses & Children's Vision
Laser Vision Correction

CHERRY B. COCKRELL, O.D.
Family Optometry
Contact Lenses & Children's Vision
Laser Vision Correction

JEFF D. MILLER, O.D.
Family Optometry
Contact Lenses & Children's Vision
Laser Vision Correction

JOHN M. MILLIRONS, O.D.
Family Optometry
Contact Lenses & Children's Vision
Laser Vision Correction

CARSON M. GEE, O.D.
Family Optometry
Contact Lenses & Children's Vision
Laser Vision Correction

LAUREN S. GEE, O.D.
Family of Optometry
Contact Lenses & Children's Vision
Laser Vision Correction

Medical Record Release Request

(Please print clearly)

Step 1: Personal information

Name: ____
Date of Birth____
SSN____

Step 2: Who has the records now?

I hereby authorize:
Dr. ______________________ From the office of: ___________________________
Phone #_____________________________ Fax#___________________________
Address____________________________________ City ____________________
State_______________ Zip_____________________

Step 3: What records would you like released?

To release the following information:
[] Contact lens Rx [] Spectacle Rx [] Last Exam
[] All records [] Other:__________________________

Step 4: To whom do you wish to release your records?

To: Dr.____________________ From the office of: ___________________________
Phone #_____________________________ Fax#___________________________
Address____________________________________ City ____________________
State_______________ Zip_____________________

I understand that without this authorization, the provider is not permitted to disclose this information, as indicated by law. I further understand that this information will become part of my case history.

Thank you,

______________________________ Date________________
Patient or Legal Guardian Signature

Stillwater Office: 405.372.1715 • Fax: 405.372.3350 • 1711 West 6th • P.O. Box 2017 • Stillwater, OK 74076
www.cockrelleyecare.com