COMPLETE EYE CARE
seemorelivebetter.com

Dr. Chris Swanson | Dr. Shane Claborn | Dr. Brandon Ross | Dr. Laura England
Dr. Howard Ross | Dr. Jeremy Wiggins

If you are requesting your records **from another doctor's office,** please fill out the following:

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 Date

Patient name:_____ Date of Birth:_____

Name of Office we are requesting from: _____

Doctor's name: _____

Address: _____ City: _____ State: ___

Phone: _____

Fax: _____

Records I am requesting:_____

If you are requesting that **Complete Eye Care send records to another doctor's office,** please fill out the following:

I, _____, authorize the release of my medical records to the following offices:_____.

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

Patient name:_____ Date of Birth:_____

Name of Office we are sending to: _____

Doctor's name: _____

Address: _____ City: _____ State: ___

Phone: _____

Fax: _____

Records I am requesting to be sent:_____