Release of Records

Physician:_____

Fax:_____

I, _____, hereby authorize the release of my eye exam records to the address below. Please fax or mail all records pertaining to my visual examinations, including contact lens parameters, and ocular surgeries.

Patient Name (Print):_____

Signature:_____

Date of Birth:_____

Today's Date:_____

SEND RECORDS TO:

FAMILY VISION CARE OF PONCA CITY
DR. WILLIAM A. STUEVER
DR. KELLY C. CAMPBELL
1619 N. FIFTH
PONCA CITY, OK 74601
(580) 762 – 5700
FAX: (580) 765 – 3022
EMAIL: INFO@FAMILYVISIONEYECARE.COM