Records Release Authorization

Currently, my records are located at the office of:

Doctor:_____

Address:_____
_____
_____
_____

Phone #:_____

Fax #: _____

By my signature below, I request that my records be faxed or mailed to:

Dr. Jon Pederson
6650 S. Vine St., Ste. 160
Centennial, CO 80121
(T) 303.798.5533
(F) 303.798.2800

Please include the complete history of records in your possession, including, but not limited to, eye examination, spectacle and contact lens prescription information concerning my condition and/or treatment during the period:

From_____ TO_____

Patient Name: _____DOB_____

Address: _____
_____
_____

Signature:_____Date_____
(IF relative, relationship)