RECORDS RELEASE

Murray Scholls Vision Center
14600 SW Murray Scholls Ste. 104
Beaverton, OR 97007
Phone: 503-579-6695
Fax: 503-579-6658

I hereby authorize MURRAY SCHOLLS VISION CENTER to release my/my child's record to:

____
**Doctor/Clinic Name/Hospital/Other*

____
Address

_________________________ _________________________
**Fax* *Phone*

Please specify: Spectacle RX Contact lens RX

PATIENT INFORMATION

*Name: ____
Please Print

Address: ____

*DOB: _________________________ Phone: _________________________

*Signature: ____

*Date: _______________________ *Relationship to patient: _______________________

**Required Information*

Confidentiality note:
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