Mid-Valley Eyecare

VISION SOURCE®

Where ***EYECARE*** means "***I CARE***"

Christopher D. Johnson, OD, FAAO Optometric Physician

986 SE Uglow Avenue • Dallas, OR 97338 • (503) 623-3538 • www.mveyecare.com

PATIENT RECORD/INFORMATION RELEASE FORM

I authorize_____to release any information necessary provide health care, including medical records, charts, test results, notes, and other records. I request that a copy of these records be faxed to:

Dr. Christopher Johnson
Mid-Valley Eyecare
Fax# (503) 623-8112

Patient Name: _____

Date of Birth: _____

Signature: _____ Date: _____

In the event the patient is a minor or individual under guardianship, power of attorney, or conservatorship, the person signing must be duly authorized to serve in such capacity and sign below for the patient:

Signature: _____ Date: _____

Name: _____ Relationship: _____

Comments/Reason: _____
_____
_____
_____