SPECIALTY Eyecare Group
a member of VISION SOURCE™

David L. Kading, OD, FAAO, FCLSA Kristi Kading, OD, FAAO, FCOVD Katherine Shen, OD Charissa Young, OD, FAAO

Records Release Authorization

Patient Name: _____ DOB _____

Patient/Guardian Signature: _____ Date: _____

□ Incoming Records:

Doctor or Clinic requesting records from: _____

Phone: _____ Fax: _____

I hereby authorize and request you to release all my medical and vision records to Specialty Eyecare Group. Please send copies of all imaging as well as diagnostic and treatment recommendations.

□ Outgoing Records:

I hereby authorize Specialty Eyecare Group to furnish my eye health and vision records to:

Doctor or Clinic requesting records to be sent to: _____

Address: _____

Phone: _____ Fax: _____