Schmidt EyeCare, LLC **Kimberly Schmidt, OD**

333 S. State Street, Suite T
Lake Oswego, OR 97034
Phone: (503) 636-2762 Fax: (503) 636-4502

Authorization to release Medical Information:

Patient Name:_____ DOB:_____

Address:_____

Phone number:_____

At my request, I Authorize:	To release my records to:
Name:	Name: SCHMIDT EYECARE
Address:	Address: 333 S. State St. Suite T
	Lake Oswego, OR 97034
Phone:	Phone: (503) 636-2762
Fax:	Fax: (503) 636-4502

Specifically, I authorize the use or disclosure of the following information:

____Complete records ____Contact lens order

____Surgery records ____Diagnostic tests

____Other:_____

Signature of Patient/Patient Representative:_____
Print Name:_____
Relationship to Patient:_____
Date signed:_____