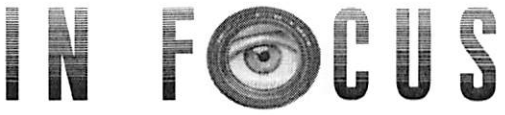
# Records Release Request

**Date:** _____

**Doctor:** _____

**I authorize the release of vision and/or medical records, or copies of such, and request that they are transferred to:**




EYE CARE CENTER

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Las Vegas, NV 89129-7455

Phone (702) 790-2400

Fax: (702) 790-2441

Email: eyeman@karlmlarsenod.com

**Patient Name:** _____

**D.O.B:** _____

**X**_____

**Patient, Parent, or Legal Guardian Signature**