COCKRELL EYECARE CENTER

DAVID A. COCKRELL, O.D., F.A.A.O.
Family Optometry
Contact Lenses & Children's Vision
Laser Vision Correction

CHERRY B. COCKRELL, O.D.
Family Optometry
Contact Lenses & Children's Vision
Laser Vision Correction

JEFF D. MILLER, O.D.
Family Optometry
Contact Lenses & Children's Vision
Laser Vision Correction

JOHN M. MILLIRONS, O.D.
Family Optometry
Contact Lenses & Children's Vision
Laser Vision Correction

Medical Record Release Request

(Please print clearly)

Step 1: Personal information

Name:_____
Date of Birth_____
SSN_____

Step 2: Who has the records now?

I hereby authorize:
Dr. _____; From the office of:_____
Phone #_____ Fax#_____
Address_____ City_____
State_____ Zip_____

Step 3: What records would you like released?

To release the following information:
[] Contact lens Rx
[] Spectacle Rx
[] All records
[] Other:_____

Step 4: To whom do you wish to release your records?

To: Dr._____; From the office of: _____
Phone # _____ Fax #_____
Address_____ City_____
State_____ Zip_____

I understand that without this authorization, the provider would not be permitted to disclose this information, as indicated by law. I further understand that this information will become part of my case history.

Thank you,

_____ Date_____
Patient or Legal Guardian Signature

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