



1033 Coffeen Avenue ~ Sheridan, WY 82801  
Phone (307) 674-0444 ~ Fax (307) 673-0860

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**AUTHORIZATION FOR RELEASE OF RECORDS**

Patient name

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Patient date of birth

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Patient address

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Patient phone number

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Patient Signature

**X** \_\_\_\_\_

I authorize \_\_\_\_\_ to release all my eyecare records to Eye Care of the Big Horns, LLC.

\_\_\_\_\_ Glasses Rx / Contact lens Rx

\_\_\_\_\_ Clinical records

Patient is waiting in our office: Yes \_\_\_\_\_ No \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_