Rebecca J. W. Brown, OD
Willard J. Stamp, OD
389 N. Ellsworth Ave.
Salem, OH 44460
phone/fax (330) 332-1200

Date: ___________________

Attention: ____________________________

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the check mark(s) below) or to otherwise release confidential information. At this time I am requesting the following:

__________ Spectacle prescription

__________ Contact Lens prescription

__________ Complete record

__________ Records of care from _____________________ to ________________ only

__________ Records of care concerning the following condition(s)

____

__________ Other. Specify:
____

to:

Rebecca J. W. Brown, OD
Williard J. Stamp, OD
389 N. Ellsworth Ave.
Salem, OH 44460
phone/fax (330) 332-1200

Print Name: ____

Signed:____ Date: ___________
(Patient or person legally authorized to consent on patient's behalf)

D.O.B__________________