11421 E. CARSON STREET SUITE D, LAKEWOOD, CA 90715
TEL: (562)860-4590 FAX: (562)860-4591
www.LiveLifeOptical.com
LiveLifeOptical@gmail.com

MEDICAL RECORDS RELEASE/ REQUEST FORM

I, _____ Date of Birth:_____

Address: _____

Telephone: _____

hereby authorize Office/Dr._____

Address_____

Tel:_____Fax:_____

□ Release Spectacle Prescription

□ Release Contact Lenses Prescription

□ Release Medical Records

To : LIVE LIFE OPTICAL 11421 E.Carson Street Suite D, Lakewood, CA 90715

_____ _____

Patient's Signature
(parent or guardian)

Date

Fax # 1-562-860-4591