CORGAN
VISION CLINIC

---

# Authorization For Records Release

To:______________________________

Address:__________________________

________________________________

I hereby authorize and direct you to release to:

Corgan Vision Clinic, SC
2706 Cahill Road, Suite E.
Marinette, WI 54143
Fax 715-330-5369

Timothy J Corgan, O.D.

A summary of eyecare in your office: including diagnosis, treatment, refraction and keratometry readings during the time I have been your patient. Thank you.

Date_______________

Patient Name______________________________DOB______________

Address_____________________________________________________

____________________________________________________________

Patient Signature___________________________________________

---

2706 Cahill Road, Suite E
Marinette, WI 54143
715-330-5570