



Authorization For Records Release

To: _____

Address: _____

I hereby authorize and direct you to release to:

Corgan Vision Clinic, SC
716 Pierce Avenue
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 _____