Edmond Regional Eye Associates, Inc.
Robert D. Gourley, MD & M. Andrew Hogue, MD
920 S. Bryant Ste 100
Edmond, OK 73034
Phone: 405-341-4238
Fax: 405-340-0269

# RECORDS RELEASE

DATE: _____

TO:_____(Doctor or facility)
_____(Address)

_____( Phone)
_____ (Fax)

I hereby authorize and request you to release to Edmond Regional Eye Associates, Inc. (Robert D.Gourley, MD or M. Andrew Hogue, MD) my complete medical record in your possession, concerning my illness and/or treatment as well as glasses prescription and contact prescriptions during the period from_____to_____.

Printed Name: _____
Date of Birth: _____

Signed:_____
Date:_____