

## Medical Records Release

Shafer Vision Care, P.C.  
67 E. Garner Road, Suite 800  
Brownsburg, IN 46112  
(317) 852-5000 phone  
(317) 852-5009 fax



Date: \_\_\_\_\_

I hereby release the below marked patient information to  
Shafer Vision Care, P.C.

\_\_\_\_\_ Complete medical history and records

\_\_\_\_\_ Contact lens prescription

\_\_\_\_\_ Eyeglass prescription

Please send the information to the above fax number. Thank you for your prompt  
attention to this matter.

Sincerely,

\_\_\_\_\_  
Patient's signature or guardian

\_\_\_\_\_  
Printed patient's name

\_\_\_\_\_  
Date of birth