California Avenue Optometry
& Contact Lens Clinic
456 S. California Avenue
Palo Alto, CA 94306

Tel (650) 617-2020
Fax (650) 617-4550

Dan A. Baggett, O.D.
Shawna Lovering, O.D.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please release a copy of all Medical and Optometric information contained in my medical record on file in your office.

Please include a copy of the following information:

1. The most recent examination record, including date of exam.
2. A complete summary of all Contact Lenses ordered and/or received, complete with all specifications and parameters, along with the most recent date received.
3. The most recent refraction and date:

   O.D. _____ 20/_____ Add: _____

   O.S. _____ 20/_____ Add: _____

4. The most recent Keratometry Readings:

   O.D._____ @ _____ degrees. Mires _____

   O.S._____ @ _____ degrees. Mires _____

PATIENT _____ Date of Birth _____
(Print name)

SIGNATURE _____ DATE _____

Please FAX a copy of all information to the above FAX number.