Prescription / Records Request

Date: ________________

To Whom It May Concern: ____, is requesting release of his/her medical records.

Date of Birth: __________________________________.

Please send to:

Freedom Optical, Inc. 217 King Street, Cocoa FL. 32922

Or fax to us at: 321.208.8019

Or Email sales@freedomopticalinc.com Attention Kim

Patient Signature: ______________________________

Thank you.