



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. 120 Forrest Avenue, Cocoa Florida 32922

Or fax to us at: 321.208.8019

Or Email sales@freedomopticalinc.com Attention Stacie or Paige

Patient Signature: _____

Thank you.