IN FOCUS
EYECARE OF ROCKFORD
A Member of VISION SOURCE™

Date _____

To: _____

_____

_____

_____

My signature below serves as authorization for you to provide copies of my medical and eye care records to In Focus Eyecare of Rockford. Please fax these records at your earliest convenience.

Dates of Service:

_____ Most recent Glasses prescription

_____ All records

Dates beginning _____ and ending _____

Patient Name _____

Date of Birth _____

Phone # _____

Signature _____ _____
Printed name

Mark Swan, OD, MEd, FAAO
25 North Main Street
Rockford, MI 49341

616.866.3077 - P
616.866.4408 - F
in-focus-eyecare@att.net - E