



Glen Ellyn  
**Vision Center**  
*The Source for Complete Vision Care*

Date received \_\_\_\_\_

(office use only)

**Medical Records Release**

I hereby authorize \_\_\_\_\_

To release medical records for \_\_\_\_\_

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

To:

**Glen Ellyn Vision Center**

**440 N. Main Street**

**Glen Ellyn, IL 60137**

**Phone # (630)469-4141 Fax # (630)469-2015**

Signature required: \_\_\_\_\_