

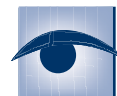
**Darrell E. Genstler, MD**  
Refractive Cataract Surgery  
Acute EyeCare  
Eye Trauma  
Glaucoma  
Dry Eye

**Benjamin M Jäger, OD**  
Primary Vision Care  
Acute EyeCare  
Glaucoma  
Contact Lenses

**Kent D Reynolds, OD**  
Primary Vision Care  
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Glaucoma  
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**Tad Abernathy**  
Practice Administrator

**Gina Steele**  
Assistant Administrator



**GENSTLER**  
EYE CENTER

## MEDICAL RECORD RELEASE AUTHORIZATION

I AUTHORIZE

\_\_\_\_\_ **MD, DO, OD**

\_\_\_\_\_  
(Address)

I authorize you to release to **Genstler Eye Center** all of my office records (including, but not limited to, diagnosis, office notes, laboratory results and letters) of my examination and treatment.

Indicated below the specific information you want released. THANK YOU.

- \_\_\_\_\_ Written Report (If unavailable, all patient records)  
\_\_\_\_\_ All Patient Records including images  
\_\_\_\_\_ Contact Lens Specifications, Refraction and Vision  
\_\_\_\_\_ Visual Fields  
\_\_\_\_\_ Other \_\_\_\_\_

**Genstler Eye Center**  
2700 14th Ave. SE  
Albany, OR 97322  
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(800)338-2009

**EyeWear Pavilion**  
(541) 926-1618

**Eye Surgery Center**  
(541) 928-1667  
Nursing Director  
Connie Arnold, RN

**Genstler Hearing Center**  
(541) 926-1667

**Web Site:** letsee.com

\_\_\_\_\_  
(Name)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Patient's Signature)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(Date Signed)

Records Release **TO** Genstler Eye Center