

To Whom It May Concern:

I, _____, hereby authorize the release of my records to Dr. James R. Dugue, Optometrist. Please forward all pertinent information.

Signed: _____

Date: _____

Thank you,

the office of:

James R. Dugue, OD
25982 Pala, Suite 270
Mission Viejo, CA 92691

Voice: (949) 951-1424
Fax: (949) 770-5471