

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  
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