# lakewood vision clinic, p.c.

O. Joseph Bebber, O.D., F.A.A.O.

Date____________________

To: ________________________

________________________

________________________

I, ________________________________________ do hereby authorize the release of my records concerning contact lenses to the Lakewood Vision Clinic, P.C., 2020 Wadsworth Blvd., Lakewood, Colorado 80215.

________________________________________

ORIGINAL "K's" OD ________________________________________

Date __________ OS ________________________________________

ORIGINAL REFRACTION OD ________________________________________

Date __________ OS ________________________________________

MOST RECENT REFRACTION OD ________________________________________

Date __________ OS ________________________________________

MOST RECENT CONTACT LENS SPECIFICATIONS
Date __________

| | BASE CURVE | POWER | DIAMETER | OPTIC ZONE |
|---|---|---|---|---|
| OD | ________ | _____ | ________ | ________ |
| OS | ________ | _____ | ________ | ________ |

PERIPHERAL CURVE DESIGN:

COMMENTS:

2020 Wadsworth Boulevard, Lakewood, Colorado 80215 • 232-0200