



Spectacle RX Release Form

I, _____ Birth Date

Home Address: _____
Street

City, State and Zip Code

Request and do give permission to Doctor _____
to release my eyeglasses prescription and to have it sent as soon as possible to the
Spectacle Shoppe, Inc.

The prescription may be transmitted via:

Fax: 316-686-7665,
Voice: 316-686-6111,
Text: 316-444-0574,
Email: info@krspecs.com

Signed, _____
Authorized Signature Date

Spectacle Shoppe, Inc., 306 N Rock Road, Ste 10, Wichita, KS 67206