

OPTIC INFORMATION

Missing Person's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

Investigating Agency's Name \_\_\_\_\_

Agency Case Number \_\_\_\_\_

Investigating Officer's Name \_\_\_\_\_

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Glasses or Contact Lenses: Yes \_\_\_\_\_ No \_\_\_\_\_

If contact lenses,  
which type: (Circle one)  
Soft Hard Semi  
Extended Wear

Type of Frames \_\_\_\_\_

Prescription:

Right eye \_\_\_\_\_

Left eye \_\_\_\_\_

Comments: (Any diseases,  
scars, etc., that will  
aid in the identifica-  
tion of the missing  
person)

Name of Optician, Optometrist, or Ophthalmologist \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, and ZIP \_\_\_\_\_

Telephone Number \_\_\_\_\_

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I am the parent/legal guardian/next of kin of the above-named missing person and I hereby authorize the release of medical records to assist criminal justice agencies in locating the missing person.

\_\_\_\_\_  
Signature of Parent/Legal Guardian/Next of Kin

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, and ZIP