Hawks Prairie Vision Clinic

2539 Marvin Rd NE Suite B
Lacey, WA. 98516
Phone: 360.459.3333
Fax: 360.459.2724

Records Release/Request Form

Requesting Date:

To:

Fax Number:

Patient Name:_____ **DOB:**_____

- ☐ Information Requested from your office:
- ☐ Complete Examination Records
- ☐ Contact lens Prescription/Records only
- ☐ Previous RX History
- ☐ Surgery notes from Latest Operation
- ☐ Other:_____

Patient's Consent:

I consent to your sharing information/records about _____ for up to six months from this date. I understand the information you will share may include diagnoses, records of any previous examinations or treatment and any additional facts or observations related to vision care, other health services, social services or education, depending on which services are being provided. I also understand that this information cannot be released without my consent (except in a medical emergency, for an audit, or with a court order) and that I have the right to revoke my consent at any time.

_____

Patient/Parent/Legal Guardian Signature **Date**

Please do one of the following:

- ☐ Fax requested information to: **360.459.2724**
- ☐ Mail requested information to: **Hawks Prairie Vision Clinic**
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  Lacey, WA. 98516