

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: _____

Patient Name: _____ DOB: _____

Information Requested from your office:

- Most Recent Examination Records
- Previous Contact Lens Prescription
- Previous Spectacle Prescription
- 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:

- | | | |
|--|------------------|--|
| <input type="checkbox"/> Fax requested information to:
360.459.2724 | <u>OR</u> | <input type="checkbox"/> Fax requested information to:
_____ |
| <input type="checkbox"/> Mail requested information to:
Hawks Prairie Vision Clinic
2539 Marvin Rd NE Suite B
Lacey, WA. 98516 | | <input type="checkbox"/> Mail requested information to:

_____ |