# RECORDS REQUEST

**I hereby authorize:** ______________________________________________

**Doctor/Clinic Name/Hospital/Other*

______________________________________________

*Address*

______________________ ______________________

**Fax* *Phone*

**To release any information contained in my (or my child's) record:**

PATIENT INFORMATION

*Name: ______________________________________________

*Please Print*

______________________________________________

**Address*

______________________ ______________________

***DOB*** ***Phone***

______________________________ ______________

**Signature* **Date*

______________________

**Relationship to patient*

**Required Information*

**To:** **WEST LINN VISION CENTER**
Dr. Bradley Smith, OD
Dr. Keely Hoban, OD, FAAO
Dr. Michael Connell, OD
Dr. Emily Bee, OD

2020 8th Avenue, Suite A
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**Phone: (503) 652-1479** **Fax: (503) 303-5587**

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