

# 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: TIGARD VISION CENTER**

Dr. Bradley Smith, OD

Dr. Elaine Wyner, OD

Dr. Rosaline Cha, OD

9169 SW Burnham Street

Tigard, OR 97223

**Phone: (503) 639-5115**

**Fax: (503) 624-0542**

Confidentiality note:

The information contained in this facsimile message is legally privileged and confidential, intended only for the use of the addressee named above. If the reader of this message is not the intended recipient, you are notified that any dissemination, distribution, or copying of this telecopy is strictly prohibited. If you received this telecopy in error, please immediately notify us by telephone and return the original message to us at the address above.