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**
Bradley Smith, OD
Kari Cline, OD
Keely Hoban, OD, FAAO

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.