Medical Records Request

Provider/Entity: _____

Address: _____

City / State / Zip: _____

Secure email: _____

Fax: _____

Information Requested:

I _____ (patient full name) authorize the above-named provider/entity to release the following designated medical information.

___ Copy of complete medical records including results of diagnostic testing
___ Copy of contact lens prescription
___ Copy of spectacle lens prescription
___ Other information_____

Release Authorized to:

Coos Bay Vision Center, Inc.
986 Central Avenue PO Box 329
Coos Bay, OR, 97420
Fax: _____

Secure email: _____

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. IF I AM SIGNING FOR A MINOR, MY SIGNATURE ATTESTS THAT I HAVE LEGAL AUTHORITY OVER MEDICAL DECISIONS FOR THE DESIGNATED MINOR.

_____ _____
Print Name DOB (unless signing for minor)

_____ Date _____ / _____ / _____
Patient or legally authorized individual signature

_____ _____
Printed name if signed on behalf of the patient Designate parent or guardian DOB of minor (if signing for minor)