REDMOND VISION CLINIC

Irene Koval, OD
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Optometric Physicians

Medical Records Release Request

Patient Name: _____ Date of Birth: ___/___/___

Address: _____ Tel: _____

☐ I hereby authorize and request Redmond Vision Clinic to **obtain** complete medical records, including illness and/or treatment from:

Office/Clinic: _____ Tel: _____

Address: _____ Fax: _____

☐ I hereby authorize and request Redmond Vision Clinic to **release** complete medical records, including illness and/or treatment to:

Office/Clinic: _____ Tel: _____

Address: _____ Fax: _____

Records Requested: Request Expires: ___/___/___

☐ All Records prior to date: ___/___/___

☐ Specific Records: _____

Please email records to STAFF@REDMONDVISIONCLINIC.COM or Fax to (425) 882-7818

Signature: _____ ☐ Parent/Guardian

PRINT name if signing for patient: _____ Date: ___/___/___