WESTBROOK **VISION** CENTER PLC.

focused on your eyes

Bethanie Deemer O.D. | Cindy Hum O.D. | Nha Cao O.D. | Todd Smith O.D.

Medical Records Release Authorization:

Patient Name: ___________________________ DOB: ______________

Address: ____

Records Needed:

- ☐ Complete Medical Records
- ☐ Contact Lens Material/Parameter
- ☐ Records From: _____________To:_____________

I, the undersigned, do hereby authorize and direct you to:

- ☐ Furnish records **TO** Westbrook Vision Center
- ☐ Release records **FROM** Westbrook Vision Center

I understand that Westbrook Vision Center does not release copies of records received from other health care providers. ***Please contact those providers for any other records.***

Check how records are to be received: [ ] Mail [ ] Fax [ ] Pick-up

Provider Information:

Name: ____

Address: ____

City: ____________________ State: _________ Zip: _________

Ph: _________________________ Fax: _____________________

Patient/Guardians Signature: _____________________Date:__________

Westbrook Vision Center 8877 w Union Hills Dr SteD460 Peoria Az 85382
Ph: 623-256-0400 Fax: 623-376-6800