Pasco Vision Clinic

Adam Good, O.D. **J.C. Sullivan, O.D.** **Bill Sullivan, O.D.**
2715 West Court Street. Pasco, WA 99301
(509) 547-8409 Phone
(509) 544-7875 Fax
www.pascovisionclinic.com

CONSENT FOR RELEASE OF MEDICAL INFORMATION

PATIENT: _____

DATE OF BIRTH: _____

TO: _____

FROM: _____

Please include the following information:

☐ **All Clinical Records**

☐ **Clinical Records only related to:** _____

☐ **Ocular Health Status**

☐ **Most Recent Refraction and/or Contact Lens Specification**

Other: _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY . I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. RECORDS MAY TAKE UP TO 7 BUSINESS DAYS.

This authorization expires 60 days from the date of the request.

Patient Signature: _____

Relationship: _____

Date: _____