HEASTON &
THOMPSON
VISION CLINIC

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REQUEST FOR PATIENT RECORDS

Patient Name:_____ **Date of birth:**_____/_____/_____

Address:_____ **Phone #:** (_____)_____

Reason for request:_____

____ I authorize Heaston & Thompson Vision Clinic to **obtain** patient records from:

_____ Ph #:_____

Address:_____ Fax #:_____

____ I authorize Heaston & Thompson Vision Clinic to **release** patient records to:

_____ Ph #:_____

Address:_____ Fax #:_____

Records Requested: Request Expires:_____/_____/_____

____ All Records prior to date:_____/_____/_____

____ Specific Records:_____

____ Other Pertinent Findings:_____

Please send records to 1321 Aaron Drive, Richland WA 99352 -or-
Fax to (509) 946-0905

I understand this authorization may be revoked at any time except to the extent action has been taken based upon it.
Information used or disclosed because of this authorization may be further disclosed by the recipient and therefore no longer protected.

Signature:_____ ( ) Parent/Guardian
Date:____/____/_____