WESTLAKE EYECARE
& optical boutique

Katie M. Kaufman, O.D.
Raeann M. Murray, O.D.

REQUEST FOR RELEASE OF HEALTH INFORMATION

Please send the following records upon receipt of this request:

- ❑ Complete Record
- ❑ Contact Lens prescription
- ❑ Last visit
- ❑ Vision therapy records
- ❑ Eyeglass prescription
- ❑ Results of Consultation / Work-up

Patient name:_______________________________________DOB: ___________________

Address: ____

I,____authorize

Dr.____at

____
Practice Name

____
Address

___________________________________ ___________________________________
Phone Fax

to release my records as noted above to:

Westlake Eyecare & Optical Boutique
4613 Bee Caves Road, Ste. 201
Austin, TX 78746
512-347-0700
512-347-0702 (fax)
officebc@westlakeeyecare.com

Westlake Eyecare & Optical Boutique
360 Nueces Street, Ste. 70
Austin, TX, 78701
512-643-2020
512-643-2200 (fax)
officedt@westlakeeyecare.com

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Signature Date