WESTLAKE EYECARE

REQUEST FOR RELEASE OF HEALTH INFORMATION

Patient name:_____ DOB:_____

Address:_____

Please send the following records upon receipt of this request:

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

I authorize Dr. _____ at _____ (Practice Name)

Address:_____

Phone:_____ Fax:_____

to release my records as noted above to:

Westlake Eyecare PLLC
4613 Bee Caves Road, Suite 201
West Lake Hills, TX 78746

Westlake Eyecare PLLC
360 Nueces Street, #70
Austin, TX 78701

Signature:_____ Date:_____