RECORDS REQUEST

I hereby authorize: _____

**Doctor/Clinic Name/Hospital/Other*

_____

Address

_____ _____

**Fax* *Phone*

To release any information contained in my (or my child's) record:

PATIENT INFORMATION

*Name: _____

Please Print

_____

**Address*

_____ _____

**DOB* **Phone*

_____ _____

**Signature* **Date*

_____

**Relationship to patient*

**Required Information*

To: **MURRAY SCHOLLS VISION CENTER**
Dr. Bradley Smith, OD
Dr. Keely Hoban, OD, FAAO
Dr. Michael Connell, OD
Dr. Emily Bee, OD

14600 SW Murray Scholls Dr., Suite #104
Beaverton, OR 97007
Phone: (503) 579-6695 **Fax: (503) 579-6658**