



**Lake Stevens
Vision Clinic**

Rodney A. Windhorst, O.D.

Request for Patient Records Release

Date: _____

_____ hereby requests release of all records from Lake Stevens Vision Clinic. Records containing spectacle and/or contact lens specifications, general exam data, and health history notes are included

I, _____, hereby give Dr. Rodney A. Windhorst at Lake Stevens Vision Clinic permission to release a full copy of my records to:

Dated: _____

All family member records are to be included in this request for records release

Print Name

Signature

515 Highway 9, Suite 104
Lake Stevens, Washington 98258
(425) 334-4016 Fax (425) 334-4017