AARON M. BANTA, OD
AARON D. QUNELL, OD
PETER S. WAGONER, OD

8127 W. Grandridge Blvd. Suite 110
Kennewick, WA 99336
Phone: 509-783-8383
Fax: 509-735-2592
www.centervisionclinic.com

Authorization to Release Healthcare Information

Patient name: _____ DOB: _____

I hereby request and authorize **Dr. Banta, Dr. Qunell, or Dr. Wagoner** to **release**, by mail or fax, healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____Fax: (_____)_____

This request and authorization applies to:

- All healthcare information
- Healthcare information related to the following conditions, treatments, or dates:

  _____

X_____ _____
Signature of patient or guardian Date

Relationship to patient if signed by anyone other than the patient

_____

This authorization expires on_____ or 1 year after the signed date above.