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

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Kennewick, WA 99336
Phone: 509-783-8383
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Authorization to Request Healthcare Information

Patient name: _____ DOB: _____

I hereby request and authorize **Center Vision Clinic** to **receive**, by mail or fax, healthcare information of the patient named above from:

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:

  _____

ATTN: Aaron M. Banta, OD Aaron D. Qunell, OD Peter S. Wagoner, OD

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.