

REQUEST FOR MEDICAL RECORDS RELEASE

Patient(s)

Date of Birth

Records From: _____

Records To: **Wichita Vision Care**
Kevin Cline, OD & Trevor Askew, OD
12111 W. Maple, Ste 125
Wichita, KS 67235
Ph#: (316) 832-0088
Fax#: (316)832-0029

Patient Signature: X _____
(Parent Signature if requesting records for children)

Phone: X _____

Date: X _____