Tacoma Eye at Westgate

6004 N Westgate Blvd Suite #180

Tacoma, WA 98406

Phone: 253-220-2563

COVER PAGE

TO PATIENT: Please complete the information on this form (2 sides) and send this to your previous eye doctor's office so we may have your records prior to your *eye exam*

DATE:_____

PREVIOUS EYE DOCTOR OR CLINIC NAME:

PREVIOUS EYE DOCTOR OR CLINIC FAX NUMBER:

PREVIOUS EYE DOCTOR OR CLINIC PHONE NUMBER:

Tacoma Eye at Westgate

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Tacoma, WA 98406

Phone: 253-220-2563

PATIENT INFO:

Patient Name: _____

Patient Date of Birth: _____

Patient Signature: _____

(must be signed by pt to be valid)

Dear Provider:

This is a request for **previous medical records** for the above named patient. We kindly ask that the medical records be faxed to us within 5 business days from the date on the cover sheet.

Please Fax to **253-487-7034** "Attention Front Desk" or you may email a .PDF of the chart notes to frontdesk@tacoma-eye.com

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NOTES: