

Patient Record Request Form

I hereby request my records (including all imaging and visual field results) be transferred to West 5 Optometry.

Patient Name: _____ Previous Office/Doctor: _____

Date of Birth: _____ Today's Date: _____

Signature: _____

Thank you in advance for the transfer of the files, images and all other information. You can email the files to welcome@west5o.com or fax to 519-471-5757

Thank you,

West 5 Optometry