Brainerd Eyecare CENTER

Caring for the health of your eyes.

PATIENT AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Patient Name: ______________________ Date of Birth: ___________

TO: ________________________ FROM: ____________________

________________________ ________________________

________________________ ________________________

I authorize the release of the following personal health information:

___Eye examination records and progress notes

___Visual fields

___Consultation letters

___Contact lens information including all contact lens specifications

___Other

The purpose for the release is:

___at the request of the patient

___continuing optometric care

___other _________________

Expiration date of authorization:

___upon revocation in writing

___ event _________________

___ other _________________

Patient signature ____________________________ Dated ____________

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this release form. Relationship to patient_______________

Print name______________________ Source of authority__________________

___**Please send copies of the requested information to Brainerd Eyecare Center**

___**Brainerd Eyecare Center will send copies of requested information upon written authorization**

Doctors of Optometry

Steven T. Monda • Joshua J. Hanske • Alicia M. Archibald • Taylor J. Swanson • Michael K. Monda

506 Laurel Street • Brainerd, MN 56401 • (218) 829-0946 • Fax (218) 829-1279

www.brainerdeyecare.com