Records Release Form

Patient information:

Name: ______________________________ Date of Birth: ______________

Address: ____

Phone: ____________________ Email:______________________________

Organizations Involved:

Name/Organization:______________________________________

Address:____

Phone:_________________________ Fax:__________________________

☐ Release information **to**

☐ Receive information **from**

Crystal Vision Clinic
5200 Douglas Drive, Crystal, MN 55429
Phone: 763-537-3213 **I** Fax: 763-537-6732 **I** Email: Info@crystalvisionclinic.com

Information to be Released:

☐ All Health Information ☐ Billing Records ☐ Most Recent Visit

☐ Information from a Specific Date______________________

By signing this form, I understand that I am requesting the information specified to be released to the identified party. I understand that the form will be valid for one full year unless otherwise stated here. (_______________) I also understand that I may relinquish this validation at any time, by sending a written letter to the party sending the information.

Signature: ______________________________________ Date:______________