MEDICAL RECORDS RELEASE FORM

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____
State/Zip: _____ Phone: _____

I authorize:

Cornea and Contact Lens Institute of Minnesota
5201 Eden Ave # 150
Edina, MN 55436
Fax: (952) 657-5745
Phone: (952) 300-2151

☐ **To release information to**
☐ **To obtain information from** *(Check either or both boxes as needed)*

_____
Name/Title Organization

_____
Street Address City State Zip

_____
Fax Number Phone Number

Records Requested:

☐ Eye/vision exam records
☐ Psycho educational report(s)
☐ School records/IEP report(s)
☐ X-Ray/Lab/Misc. Report(s)
☐ Special report(s)
☐ All information
☐ Other _____

By signing below, I am attesting that I have legal right to authorize the release of my/this patient's records. I understand that I generally may revoke this authorization at any time by written notification.

_____ _____
Print name of Patient **Date**

_____ _____
Signature of Patient/Authorized Representative **Relationship to Patient**