

MEAD EYECARE & EYEWEAR RECORDS RELEASE AND REQUEST

TO FROM

MEAD EYECARE & EYEWEAR FAX: 651-735-9322	RYAN ISAACSON, OD ANNE SILL, OD CHARLES MEAD, OD	1502 WOODLANE DR WOODBURY, MN 55125 TELE: 651-735-9550 EMAIL: meadiii@meadeyecare.com
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TO FROM

CLINIC: _____ PROVIDER: _____

ADDRESS: _____

FAX: _____ TELE: _____

PURPOSE OF RELEASE:	<input type="checkbox"/> REQUEST OF INDIVIDUAL	<input type="checkbox"/> REQUEST OF CLINIC	<input type="checkbox"/> CONTINUED CARE	<input type="checkbox"/> OTHER
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TO BE RELEASED:	<input type="checkbox"/> EXAM(S)	<input type="checkbox"/> TESTING	<input type="checkbox"/> RX
<input type="checkbox"/> EXPIRATION	<input type="checkbox"/> MOST RECENT	<input type="checkbox"/> OCT	<input type="checkbox"/> OTHER
FROM:	FROM:	<input type="checkbox"/> VISUAL FIELD	DESCRIPTION:
TO:	TO:	<input type="checkbox"/> OPTOMAP	

I understand that by signing this form, I am requesting that the health information specified be sent to a third party named above. I may stop this consent at any time by written or electronic note. If the organization, facility or professional has already released health information based on my consent, my request to stop will not work for that health information. I understand that when the health information specified is sent, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws.

I have read and understand this form. I authorize the disclosure of my Health Information as described in this form.

PATIENT: _____ DOB: _____

TELE: _____ CELL: _____

ADDRESS: _____

SIGNATURE: _____ DATE: _____