POLARIS EYE CARE RECORDS RELEASE AND REQUEST

☐ **TO** ☐ **FROM**

POLARIS EYECARE **FAX: 651-735-9322**	RYAN ISAACSON, OD ANNE SILL, OD	1502 WOODLANE DR WOODBURY, MN 55125 TELE: 651-735-9550 EMAIL: meadiii@meadeyecare.com

☐ **TO** ☐ **FROM**

CLINIC: PROVIDER:

ADDRESS:

FAX: TELE:

PURPOSE OF RELEASE:	☐ REQUEST OF INDIVIDUAL	☐ REQUEST OF CLINIC	☐ CONTINUED CARE	☐ OTHER
TO BE RELEASED:	☐ EXAMS	☐ TESTING	☐ RX	
☐ EXPIRATION	☐ MOST RECENT	☐ OCT	☐ OTHER	
FROM:	FROM:	☐ VISUAL FIELD	DESCRIPTION:	
TO:	TO:	☐ 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 (print name): DOB:

TELE: CELL:

ADDRESS:

SIGNATURE: DATE: