Eye Associates
OF ALEXANDRIA

*** Dr. J. Anderson * Dr. J. Hoven * Dr. M. Hoven * Dr. C. Stotesbery * Dr. J. Kryder**

Authorization To Release Optometry Records

Patient Information:

Name (Print): _____ Date of Birth: _____

Information To Be Released From:

Name of Facility or Provider:_____

Information To Be Sent To:

Eye Associates of Alexandria
1610 Broadway Street
Alexandria, MN 56308
Phone: (320) 763-4321
Fax: (320) 763-6921

Requesting Provider:_____

Information To Be Released:

☐ Last 2 (or most recent) years of eye exam notes (Exam Summary, Special Testing, Etc.)

☐ Other: (Please Specify):_____

Patient Authorization:

I understand that my records may contain information regarding a diagnosis or treatment. I authorize the use or disclosure of the above specified information to be retrieved for medical purposes only.

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

Signature: _____ Date: _____

(Patient, Guardian*, or Authorized Representative*)

This authorization will expire 90 days from the date signed.