

Eye Surgeons & Physicians

109 Doctors Park, St. Cloud, MN 56303
ph (320) 257-2020 fax (320) 257-8382

Andrea Joplin, MD -- Mitchell Gossman, MD -- Michael Eichler, MD --- Shannon Cabrera, MD --- John Dvorak, MD -- Cindy Gellner, OD

AUTHORIZATION FOR RELEASE OF RECORDS

PATIENT'S FULL NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____

FEE

For records dating prior to 4/24/2014, we charge a flat fee of \$6.50.
Please mail a check made out to "Eye Surgeons & Physicians" along with this form.

REQUESTING RECORDS FROM:

PLEASE SEND RECORDS TO:

INFORMATION REQUESTED:

- | | |
|---|--|
| <input type="checkbox"/> Specific Dates / Years of Treatment _____ | <input type="checkbox"/> Medications _____ |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Operative Notes (incl History & Physical) | <input type="checkbox"/> Records Received from Other Providers |
| <input type="checkbox"/> Consult Reports | |
| <input type="checkbox"/> Pathology, Lab, Radiology Reports ordered by Eye Surgeons & Physicians | |
| <input type="checkbox"/> Information pertaining to HIV / AIDS, Chemical Dependency or Psychotherapy (must specifically request) | |
| <input type="checkbox"/> Other _____ | |

** I understand that this authorization will expire one year after it has been signed.

** I understand that I may revoke this authorization at any time by notifying the providing organization in writing.
Such revocation will be effective the date notified, except to the extent action has already been taken in reliance upon it.

** I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.
See Eye Surgeons & Physicians "Notice of Privacy Practices" for its policies on use and disclosure of protected health information.

** I understand that a photocopy or fax of this form is the same as the original.

PATIENT SIGNATURE: _____ DATE: _____

OR

GUARDIAN SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____