Cottage Grove EyeCare
your local Vision Source

AUTHORIZATION TO TRANSFER MEDICAL INFORMATION

Patient Name: _____ D.O.B. _____ Phone: _____

AUTHORIZE DISCLOSURE FROM:

_____
Name of Health Provider/Organization/Individual

_____
Street Address

_____
City State Zip

TO RELEASE MEDICAL INFORMATION TO:

_____
Name of Health Provider/Organization/Individual

_____
Street Address

_____
City State Zip

INFORMATION TO BE DISCLOSED:

Date Range: _____ to _____

□ Office Visit Notes □ Immunization Records □ Eye Records □ Optical RX □ Health History

Other: _____

In accordance with HIPPA regulations, I understand my rights and authorize my medical information to be disclosed to/from the above address.

_____ _____

Patient or Legal Representative Signature Date of Signature

COTTAGE GROVE EYE CARE

427 W. Cottage Grove Rd. Cottage Grove, WI 53527 - Phone: 608.839.0980 - Fax: 608.839.0982

www.cgeyecare.net