Twin Cities Eye
CONSULTANTS

Clinic Address:

Tel 612-999-2020

_____
Street Address

_____
City State Zip

MEDICAL RECORDS REQUEST AND AUTHORIZATION FORM

Print Patient full name	
Date of birth	
Address	
Phone	

1. I hereby request and authorize_____
to release my medical records to Twin Cities Eye Consultants.

_____ Specific date of service _____

_____ All records*

Method of delivery: choose one.

_____ Mail to: Twin Cities Eye Consultants
Cameron Medical Center
3777 Coon Rapids Blvd NW, Suite 100
Coon Rapids, MN, 55433

_____ Fax to: 763-421-0730

2. I authorize Twin Cities Eye Consultants to release the following records:

_____ Specific date of service _____

_____ All records*

Method of delivery: choose one.

_____ Mail to: _____

_____

_____

_____ Fax to: _____

_____ _____
Patient/Legal Representative Signature Date

*Please note, indicating "All records" will include any records from previous providers which may include HIV/AIDS status, cancer diagnosis, mental health records, drug/alcohol abuse, sexually transmitted disease, and other medical history information. You are hereby authorizing disclosure of all information within your record.