Twin Cities Eye
CONSULTANTS

Tel 612-999-2020

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

_____ 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