

MEDICAL RECORDS REQUEST AND AUTHORIZATION FORM

Print Patient Full Name	
Date of Birth	
Address	
Phone	
Purpose for release:	Continuity of Care Personal Use Legal Insurance Other: _____

Please complete only the section that fits your needs:

I hereby request and authorize the provider below to release my medical records **to** Twin Cities Eye Consultants.

Provider and Practice Name: _____

Practice Address: _____

Please indicate the records needed:

Specific date(s) of service: _____

All records*

Select one method of delivery:

Mail to: **Twin Cities Eye Consultants**
 3777 Coon Rapids Blvd NW, Suite 100
 Coon Rapids, MN, 55433

_____ Fax to: 763-421-0730

----- **OR** -----

I hereby request my medical record **from** Twin Cities Eye Consultants and ask they be sent to the practice or individual identified below.

Please indicate the records needed:

Specific date(s) of service: _____

All records*

Select one method of delivery:

Mail to: _____

Fax to: _____

By signing below, I consent to having my records released as outlined above. I understand that this request is valid for 1 year unless specified in writing. I understand that there is no "lifetime" or "open-ended" authorization for this release.

 Patient/Legal Representative Signature

 Date