

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:

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

Provider and Practice Name: _____

Practice Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

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

Questions?

_____ Fax to: 763/374-6347 Phone: 763/592-8430

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2. I hereby request my medical record(s) 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