PRECISION EYE CARE
Your Vision. Our Focus.

: 952-442-2015
: 952-442-2070
: www.PrecisionEyeCareMN.com
753 Marketplace Drive, Waconia, MN 55387

Medical Records Release Form

Releasing information from us to you or your provider

Name:_____ Address:_____

Date of Birth:_____ Phone:_____

** I authorize Precision Eye Care to release health information identifying me under the following terms and conditions:

1. Detailed description of information to be released

_____Glasses/Contact lens prescription
_____Complete Medical Record
_____Other:_____

2. To whom may the information be released to (name (s), address (es) and phone).

Name: _____

Address:_____

Phone: _____

I may stop this consent at any time by writing to the organizations(s), facility(ies) and/or professional(s) named above. If the organization has already released health information based on my consent, my request to stop with not work for that health information.

I understand that I have the right to inspect and copy the information to be released.

I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.

I understand that the release of information may not be re-released to any other person or organization without my written consent.

I have read and understood this form. I am signing it voluntarily. I authorize this disclosure of my health information as described in this form.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:
Date____/_____/_____ or specific event:_____

Signature:_____ Date:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name:_____

Source of Authority:_____

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Medical Records Request Form

Requesting information from another provider to us

I hereby authorize _____ to release my medical records to:

Precision Eye Care
753 Marketplace Drive
Waconia, MN 55387
Phone: (952) 442-2015
Fax: (952) 442-2070

1. **Detailed description of information to be released**

   _____Glasses/Contact lens prescription
   _____Complete Medical Record
   _____Other:_____

2. **Reason(s) for releasing information**

   ___Patient's request
   ___Review patient's current care
   ___Treatment/continued care
   ___Insurance application
   ___Other (please explain) : _____

I may stop this consent at any time by writing to the organizations(s), facility(ies) and/or professional(s) named above. If the organization has already released health information based on my consent, my request to stop with not work for that health information.

I understand that if the organization named is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form.

I have read and understood this form. I am signing it voluntarily. I authorize this disclosure of my health information as described in this form.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here:
Date____/_____/_____ or specific event:_____

Patient Name:_____ Date of Birth:_____

Patient Signature:_____ Date:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ Print Name:_____

Source of Authority:_____