ADVANCED OPTICAL
Eye Care Center

FAX 218-741-0800

Phone218-741-3000

Advancedoptical3000@gmail.com

OPTOMETRIST/CLINIC:_____

ADDRESS:_____

_____

FAX NUMBER: _____ PHONE:_____

Date:_____/_____/_____

I authorize the above named Optometrist/Clinic to release all previous records in their possession for the following:

Patient Name:_____

Current Address:_____

_____

Phone Number:_____

Information should be released to Advanced Optical, Dr. Jeffery Melicher O.D. at the above detailed fax or email address indicated as soon as possible.

This information is being requested at the Request of the Named Patient and/or Authorized Custodial Individual as indicated below.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to our office.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, State or federal law changes this possibility.

_____ _____/_____/_____

Signature Dated

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_____ Printed Name_____

Source of Authority_____(Parent, Power of Attorney, Court Appointment)