McDonald Eye Care Associates
20094 Kenwood Trail PO Box 847
Lakeville, MN 55044
Phone: (952)469-EYES(3937)
Fax: (877)795-9884
www.mcdonaldeyecare.com

EST 1983
McDONALD
EYE CARE
ASSOCIATES

RELEASE OF MEDICAL RECORDS AUTHORIZATION FORM

Patient Information:

Patient Name:
Patient Date of Birth:
Address:
Home Phone#: **Work Phone#:** **Ext:** **Cell Phone#:**

I am requesting my medical records be released from:

Clinic/Doctor:
Address:
Phone#:
Fax#:

I am requesting my medical records be released to:

Physician/Clinic/Other:
Address:
Phone#:
Fax#:

Please check ONE of the following:

☐ I wish to obtain a summary of the requested records
☐ I wish to inspect the requested records (in the office)
☐ I wish to obtain a copy of the requested records (fees may apply with this option)
☐ I wish to inspect and obtain a copy of the requested records (fees may apply with this option)
☐ I wish to communicate electronically* knowing that standard email and text communication may not be totally secure, I still consent to communications from my doctor or staff through my standard email and texting devices.

**This can include written and verbal communications if necessary*

Details if necessary:

I hereby authorize the release of a copy of the patient's medical records as requested.

Authorizing Person's Name: _____
(Patient, Parent, or Guardian)

Relationship to Patient: _____

If you are legally authorized representative of the patient, please sign, date and indicate your relationship to the patient. You may be asked to provide documents showing that you are the patient or patient's legally authorized representative

Authorizing Signature: _____ **Date:** _____
(Patient, Parent, or Guardian)

Authorization Expires On: _____
This consent will expire in 1 year from the date of your signature, unless you indicate an earlier date or event.