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

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

I am requesting my medical records be released to:

Physician: ____
Clinic: ____
Address: ____
Phone#: __________________
Fax#: _____________________

Please check ONE of the following:

☐ I wish to inspect the requested records
☐ 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.