



EYE CARE CENTER

Authorization For Release of Patient Records

Release to the Eye Care Center

I hereby authorize the release of my medical records and any applicable prescription information to the Eye Care Center from the following clinic:

Name of Clinic/Doctor: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

Please send or fax to the Eye Care Center location marked below

Release from the Eye Care Center

I hereby request that the Eye Care Center release my medical records and any applicable prescription information to the following clinic:

Name of Clinic/Doctor: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

❖ Patient Name: _____

❖ Patient DOB: ____/____/____

❖ Patient Signature: _____

❖ Date: ____/____/____

1202 East Moore Lake Drive, Fridley, MN 55432
Phone: (763) 574-0075 Fax: (763) 574-0594

1965 11th Avenue E, Suite 101, Maplewood, MN 55109
Phone: (651) 777-3555 Fax: (651) 777-4459