River Valley Eye Professionals

Patient Request for Access to Patient Health Information

Patient Name (Last, first, middle initial)

Street Address | City | State | Zip

Date of Birth | Day Phone | Evening Phone

Information Released From	Information Released To
Name of Clinic: River Valley Eye Professionals	
Facility Address: 2019 Jefferson Road Suite A Northfield, MN 55057	
Phone: 507-645-9202	
Fax: 507-645-9203	

Information to be disclosed:

☐ Clinic visit notes ☐ Contact lens records ☐ Refractive records
☐ Laboratory reports ☐ Medication records ☐ Consultations ☐ Operative notes
☐ **All records Eye Records including all of the above**

Purpose for release of Information:

☐ Treatment and related uses
☐ Other (explain):_____

I give permission to the PROVIDER to release Medical Record Information to the above-named physician, facility, or person. The information released will be restricted by any INFORMATION LIMITATIONS outlined above, and may be used only for the purposes described.

I understand that this release will take effect on the date signed and will be in effect for one year.

I understand that I can cancel this release at any time by notifying the PROVIDER in writing that my cancellation will take effect when the PROVIDER received my written notice. I understand that my cancellation will not have any effect on information released before the PROVIDER received my written notice. Health information used or disclosed may be subject to re-disclosure by the recipient and no longer protected by the privacy rule.

I understand that I am entitled to receive a copy of this authorization.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Authority to act on behalf of Patient Date