

# Richie Eye Clinic

Michael G. Richie, MD

Murray H. Hanson, OD Bruce V. Gustafson, OD

1575 20<sup>th</sup> Street NW Ste 101

Clinic 507-332-9900 Optical 507-332-9800

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### Clinic: Information released to:

Clinic Name \_\_\_\_\_  
Provider Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Recipient: Information released from: **Richie Eye Clinic**  
**1575 20<sup>th</sup> Street NW Ste 101**  
**Faribault MN 55021**

Information to be disclosed: **Complete Eye Chart Record Including Optical**

### Reason for Release:

- |  |  |
|--|--|
| <input type="radio"/> Legal                  | <input type="radio"/> Selected New Physician |
| <input type="radio"/> Consult/Second Opinion | <input type="radio"/> Insurance Claim Report |
| <input type="radio"/> Out of Town Move       | <input type="radio"/> Referred by Dr. _____  |

Revocation: I understand that I may revoke this consent at any time and that the consent will automatically expire twelve months from the date of my signature. I do not authorize further release to any third party. I understand that once information is released under this authorization, this clinic and their employees and my physician cannot prevent the redisclosure of that information.

Authorization: I authorize the above provider to release the information marked above to the recipient.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Relationship to Patient if Signed by  
Guardian

\_\_\_\_\_  
Date of Patient's Signature

Records Copied: \_\_\_\_\_

By Whom \_\_\_\_\_

Medical Record Copies will be: Mailed \_\_\_\_\_

Picked Up \_\_\_\_\_