

Richie Eye Clinic

Michael G. Richie, MD Murray H. Hanson, OD Bruce V. Gustafson, OD
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1575 20th Street NW Ste 101
Clinic 507-332-9900: Optical 507-332-9800: FAX 507-332-6800

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 20th Street NW Ste 101
Faribault MN 55021

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

Reason for Release:

- Legal
- Consult/Second Opinion
- Out of Town Move
- Selected New Physician
- Insurance Claim Report
- 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 _____