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Austin Anderson, OD
Lauren Evans, OD
Amber Mayberry, OD
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Yennhi Tran, OD
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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name:_____ **Acct#**_____

Date of Birth:_____

☐ Please send Wolf Eye Center my records from:

☐ Provider Office: _____
Address: _____
_____
Phone: _____
Fax: _____

OR

☐ Please send my records from Wolf Eye Center to:

☐ Provider Office: _____
Address: _____
_____
Phone: _____
Fax: _____

This authorization is limited to the following treatment dates of _____to_____.

☐ All Clinical Records

☐ Clinical Records only related to _____

☐ Visual Fields

☐ Other_____

*Records may take up to 30 days to prepare, when do you need the records sent by? _____

I give my authorization to release a copy of my medical records or reports relating to my care. I understand this consent expires one year after the date signed. I understand I have the right to revoke this authorization, in writing, should I choose, by presenting the provider with a written revocation letter. If revoked no actions already taken by WEC based upon this authorization will be affected. Information may be redisclosed if the recipient(s) as described on this form is not required by law to protect the privacy information, and such information is no longer protected by federal health information privacy regulations.

_____ _____ _____
Printed Name of Patient or Authorized Representative Relationship Date

_____
Signature of Patient or Authorized Representative

Rev05292020rw