ANNANDALE EYE | COKATO EYE | LITCHFIELD EYE

TRANSFER OF RECORDS
AUTHORIZATION TO OBTAIN/RELEASE YOUR MEDICAL RECORDS

Authorization is needed for us to obtain/release your medical records and have them sent to/from our office.

Patient Information:

Name _____ Date of Birth:_____

Address _____

Authorization:

I authorize the release of my medical information from: _____ to be sent to_____.

Purpose(s) of This Disclosure:

☐ Continued Care ☐ Insurance ☐ Legal ☐ Personal ☐ Other _____

Please send the last two years of your records. This must include color copies of any optometric scans completed within that five-year period, which should be sent by mail.

Please send the selected records to *(check box location)*:

◯ Annandale Eye Clinic	◯ Cokato Eye Center	◉ Litchfield Eye Center
500 Elm St E. PO Box 128 Annandale, MN 55302 Phone: (320) 274-3701 Fax: (320) 274-3784 office@annandaleeyeclinic.com	115 Olsen Blvd #300 PO Box 1060 Cokato, MN 55321 Phone (320) 286-5695 Fax: (320) 286-5742 office@cokatoeyecenter.com	135 N. Sibley Ave Litchfield, MN 55355 Phone: (320) 593-3100 Fax: (320) 593-2312 office@litchfieldeyecenter.com

This authorization lasts for one year after the date of signature. It may be canceled in writing at any time. I understand that this authorization is voluntary and I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment, receive payment or affect my eligibility for benefits. My signature below indicates I have read and understand this form and that I authorize the release of information.

_____ _____

Signature of patient/patient representative **Date**

_____

Print name