AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ DOB: _____

Address:_____

Phone Number: _____

I hereby authorize Rieger Eyecare Group to

☐ Obtain records from

Name/Address/Phone/Fax

_____

_____

_____

_____

☐ Release records to

Name/Address/Phone/Fax

_____

_____

_____

_____

the following medical records:

_☐___ Last 2 (or most recent) years of eye exam notes (exam summary, special testing, etc.)

_☐___ Glasses Rx _☐___ Contact Lens Rx

_☐___ Other _____

Patient Authorization

I understand that my records may contain information regarding a diagnosis or treatment. I authorize the use or disclosure of the above specified information to be retrieved for medical purposes only.

Signature: _____ Date:_____
(Patient, Guardian or Authorized Representative)

This authorization will expire 90 days from the date signed.

Rieger Eyecare Group
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Normal, IL 61761
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office@MyBrightSight.com