ANNANDALE
EYE CLINIC

# MEDICAL RELEASE FORM
# 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 _____

Address _____

Date of Birth _____

**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 selected records to:

Annandale Eye Clinic
500 E. Elm St. PO BOX 128
Annandale, MN 55302
Phone (320) 274-3701
**Fax: (320) 274-3784**

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