CHIPPEWA VALLEY EYE CLINIC

comprehensive ophthalmology
Thomas Dow, MD
Ronald Lange, MD
Lee Hofer, MD
Roger Gray Jr., MD
Roy Olson, MD
William Hawn, MD
Thomas Harvey, MD
Heidi Jarecki, MD
Chris Buntrock, MD

retinal vascular disease
Ronald Lange, MD

refractive surgery
Lee Hofer, MD
Thomas Harvey, MD

cornea-ext eye disease
Thomas Harvey, MD

optometry
Timothy Frederiksen, OD
Siobhan Beeksma, OD
Chad Vieth, OD

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Eau Claire WI 54701
phone 715 834 8471
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710 Wolske Bay Road
Menomonie WI 54751
phone 715 235 8335
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2820 South Wisconsin Avenue
Rice Lake WI 54868
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fax 715 234 0041

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(Please complete in full)

PATIENT:

1. _____ _____
Name: Last, First, MI Date of Birth

_____ _____
Street Address

_____
City State Zip Code

2. Authorize Records Released From:

_____
Name

_____
Street Address

_____
City State Zip

3. Records Released To:

_____
Name

_____
Street Address

_____
City State Zip

4. Type or extent of information to be released: (Check all applicable categories)

____ Medical history, examination, reports
____ Operation reports
____ Treatment or tests
____ X-ray reports
____ Hospital records, including reports
____ Mental health records
____ Laboratory reports
____ Prescriptions
____ Consultations
____ HIV test results
____ Copies of all other reports
____ Alcohol, drug abuse reports

5. Purpose or need for release: _____

6. This authorization will remain in effect until: _____
Date

7. This authorization will be effective for medical records generated to the date of signature.

I understand I may revoke this authorization at any time by providing my written revocation.

_____ _____
Signature of Patient Date
(If signed by person other than patient, state relationship to patient)

Patient is: ___ Minor ___ Incompetent ___ Deceased

Legal Authority: ___ Parent or Legal Guardian ___ Next of Kin of Deceased