Patient Name _____ Date of Birth _____

Telephone _____ Social Security _____

Other Names Patient has used _____

Send Records to: Clear View Eye Clinic
595 South Illinois Ave
Mason City, IA 50401
(641) 422-3937

I [ ] do [ ] do not (check applicable box) authorize this information to be faxed. If yes, fax number: (641) 422-3939

This information is being disclosed for the purpose of Continuing Health Care.

For Healthcare Covering the Period(s) [ ] All or From: _____ To: _____

Complete Health Record to be disclosed or (check appropriate boxes):
[ ] History & Physical Exam [ ] Progress Notes [ ] Discharge Summary
[ ] X-rays/Ultrasounds/Photos/Scans [ ] Laboratory Tests [ ] Consultations

I understand that if I request copies of records for myself or a member of my family, a review of this information with my physician or other healthcare provider is encouraged. I understand that if the physician does not feel it is in my best interest, I may designate another healthcare provider to receive these records. I accept responsibility for these copies and information contained herein.

Unless other wise indicated, this authorization will expire ninety (90) days from the date of signature. The physician and employees are released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that this authorization may be evoked in writing at any time, except to the extent that action has been taken in reliance on this authorization for the purposes stated above.

I understand that there may be a fee for preparing and furnishing thus information.

_____ _____ _____
Signature of Patient or Legal Representative Relationship to Patient Date