ALBANY EYE CARE

418 S. 5th St.
Laramie, WY 82070
Brian Pieper, O.D Nikalous Tolman, O.D.

CONSENT FOR RELEASE OF OCULAR AND/OR MEDICAL RECORDS

Patient Name: _____ DOB: _____

I hereby authorize disclosure of ocular information and/or medical records obtained in the course of my diagnosis and treatment.

Please select the information you would like released:

_____ Date from: _____

_____ Complete record

_____ Contact or Spectacle Rx

_____ Other: _____

To: _____ From: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Email: _____ Email: _____

I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released to the above recipient only. I also understand that I may revoke this consent by written request at anytime. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

Date: _____ Signature: _____

Relationship: _____ Printed Name: _____