AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Date: _____

Dr. Wendy Seyller
St. Croix Vision Center
13481 60th St. N., Suite 200
Stillwater, MN 55082

Patient's Name: _____

DOB: _____

Detailed description of the information to be released:

_____

_____

To whom my information be released: _____

If you have any questions, please call me at (651) 439-6400.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated: _____ Patient Signature: _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form.

Relationship to Patient: _____ Print Name: _____

Source of Authority: _____