VALLEY EYE
Clinic & Optical

223 E First Street, Suite 101
Jordan, MN 55352
952-492-2350

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

RELEASE MY RECORDS FROM:

Name: _____

Phone: _____

Fax: _____

To

Valley Eye Clinic & Optical
223 E First Street Ste 101
Jordan MN 55352

Phone: 952-492-2350
Fax: 952-492-6162

Please release a copy of all my medical records, including but not limited to: eye examinations, contact lens information, medical information, eye tests and screenings

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MEDICAL RECORDS

Patient: _____ Date: _____