MINNESOTA OPHTHALMIC
PLASTIC SURGERY SPECIALISTS

Patient's Authorization for Release of Information

I. Name of Patient _____ Date of Birth ___ / ___ / _____

Social Security Number _____ - _____ - _____.

For the purpose of: (please check one)
___Personal review of information ___Continued Treatment
___Legal Review ___Other (please specify) _____

II. If the patient is a minor or under the guardianship of another, the parent or guardian of that patient must complete this section. If the patient is not under the care of another party, leave this section blank.

Name of Parent or Guardian _____

Date of birth ___ / ___ / _____ Social Security Number _____ - _____ - _____

III. Authorization for Release of Medical Information

I, the undersigned, authorize Minnesota Ophthalmic Plastic Surgery Specialists to release medical records in their possession to the following health care providers or individuals:

_____ _____
Name of Provider or Individual _____
_____
Address
Phone (_____) - _____ - _____
Fax (_____) - _____ - _____

_____ _____
Name of Provider or Individual _____
_____
Address
Phone (_____) - _____ - _____
Fax (_____) - _____ - _____

_____ ____ /____ / _____
Authorizing Signature Date

Expiration Date: _____

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