Cheyenne Eye Clinic

Records Request Form

Date: ___/___/___

Patient's Name: ______________________________ Date of Birth: ___/___/___

I hereby authorize Dr. ____

located at ____

____

To furnish any and all information including but not limited to visual fields, OOR reports, MRI/CT/X-ray results, special testing results, mental health records, drug and/or alcohol abuse records protected by state law, and/or HIV test results, if any (except as specifically excluded below) to:

Cheyenne Eye Clinic
1300 E 20th Street
Cheyenne, WY 82001

Phone: (307)634-2020
Fax: (307) 635-6510

Information excluded: ____

____

____

This Authorization is effective now and will remain in effect until :___/___/_____.

I understand that I may receive a copy of this authorization.

Signature: ______________________________________ Date: ___/___/___.

If not signed by patient, please include your relationship to the patient:

- □ Parent or legal guardian of minor patient.
- □ Guardian or conservator of and incompetent patient.
- □ Beneficiary or personal representative of deceased patient.

Witness signature: ____

Office Use

□ Faxed
□ Mailed

Signature: ______________________________
Date: ___/___/____