Faxed:___________________ Date: ____________________

Authorization to release patient information:

<u>ONLY THE LATEST</u>

Clinical Summary, Medication & Diagnosis Lists
<u>(ICD-10 Diagnosis Coding Please)</u>

Patient Name____________________________________ DOB__________

Address____

City_______________________ State_____________ Zip_____________

Telephone____

Reason For Release: ◯ Continued Care with Ruth A Weber O.D.

◯ Other ___________________________

Please Fax to: 920-748-1492 or Mail to:
Weber Eye Care
1081B W Fond du Lac Street
Ripon, WI 54971
920-748-1497

<u>Requesting: Latest Clinical Summary, Medication & Diagnosis Lists</u>

Facility Name_____________________________ Primary Care Physician_______________________

Address____

City_______________________ State_____________ Zip________________

I, the undersigned, give the above facility, permission to release my medical records.

Signed____ Date_______________________

This authorization for disclosure of information is effective until: ______________unless revoked by the patient in writing before that date.

Patient reports no Primary Care Physician. Signed __________________________Date________________

Patient does not grant permission to release medical records. Signed __________________________Date________________