**River Falls Eye Surgery and Laser Center**

*Anthony Novak, M.D.*
*183 E Pomeroy St.*
*River Falls, WI 54022-3506*
*715-425-0115*
*Fax 715-425-6001*

## Authorization for Release of Records

Patient Name________________________________ Date of Birth_________________________

Date(s) of Service Requested: _____________________________________
Please release: Progress notes, visual fields, OCT tests, SLT tests, other laser procedures, any correspondence regarding consults

**I hereby authorize River Falls Eye Surgery and Laser Center to (disclose / obtain) the above-named individual's health information.**

**FACILITY <u>RELEASING</u> INFORMATION:**

_______________________________________________________________________________________
**Name** **Address** **City** **State** **Zip**

______________________ _________________________
**Fax Number** **Telephone Number**

**FACILITY <u>RECEIVING</u> INFORMATION:**

_______________________________________________________________________________________
**Name** **Address** **City** **State** **Zip**

______________________ _________________________
**Fax Number** **Telephone Number**

I understand that I may revoke this consent at anytime and that upon fulfillment of the above stated purpose(s), this consent will automatically expire without may express revocation.

_____________________________________________ _____________________________________________
**Signature of Patient or Patient's Representative** **Date**

_____________________________________________
**Printed name of Patient or Patient's Representative**

_____________________________________________
**Relationship to Patient, if signed by Guardian**