1020 3rd Ave. • P.O. Box 1520
Woodruff, WI 54568
Ph: 715-356-2262 • Fax: 715-356-2257

___ Kirby D. Redman, O.D.
___ Michel P. Gelinas, M.D.
___ Benjamin K. Redman O.D.

CONSENT TO RELEASE MEDICAL INFORMATION

Name of patient ____

I authorize, ______________________ ______________________
(Institution Name) (Address)

______________________ __________ ______________
(City) (State) (Zip Code)

______________________ ______________________ to disclose to
(Fax) (Phone)

Drs. Redman & Gelinas Eye Care **(715) 356-2262** **(715) 356-2257**
(Name or Institution) (Telephone) (Fax)

P.O. Box 1520 **Woodruff** **WI** **54568**
(Address) (City) (State) (Zip)

The purpose of this disclosure is to release medical information relating to the identity, diagnosis, prognosis, and/or treatment of the above named patient pertaining to **visual treatment**, and that the purpose or need for this disclosure is for **FOLLOW UP EYE CARE.**

I hereby release you and your personnel from all legal responsibility and/or liability which may arise from the act I have authorized here.

______________________ ______________________
(Patient Signature) (Date of Birth)

______________________ ______________________
(Parent—Legal Guardian—Authorized Representative (Witness)

______________________ ______________________
(Specify Relationship) (Date)

I understand this consent may be revoked by me at any time by written notice to **Drs. Redman & Gelinas Eye Care**; also, that this consent will remain in force until ______________________, at which time the patient must see their eye-care doctor to ensure the eyes remain healthy.

NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from confidential records, which are protected by low. Unless you have further authorization, laws may prohibit you from making any further disclosure of this information without the specific written consent of the patient or legal representative involved.