1020 3rd Avenue • P.O. Box 1520
Woodruff, WI 54568
(P)715-356-2262 • (F)715-356-2257

______ Kirby D. Redman, O.D.

______ Michel P. Gelinas, M.D.

______ Benjamin K. Redman, O.D.

______ Jess M. Kovacs, O.D.

______ Ed Bustamante, M.D.

CONSENT TO RELEASE MEDICAL INFORMATION

Name of patient ______________________________

I authorize, ______________________________

Institution Name Address

______________________________ ____________ ____________

City State Zip

____

Phone Fax

to disclose to:

1020 3rd Avenue
P.O. Box 1520
Woodruff, WI 54568

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. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal privacy regulations.

______________________________ ______________________________

Patient's Signature Date of Birth

______________________________ ______________________________

Parent/Legal Guardian/Authorized representative Witness

______________________________ ______________________________

Parent/Legal Guardian/Authorized representative Date

I understand this consent may be revoked by me at any time by written notice to 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 law. 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.