The Eye Centers of Racine & Kenosha

Medical Records Authorization and Release

Patient Information:

Name_____ D.O.B._____

Address_____

City, State, Zip_____

I request a copy or summary of the following medical records:

- ☐ Complete Medical Records
- ☐ Progress Notes
- ☐ Diagnostic Reports
- ☐ Test/Treatment Forms
- ☐ Inpatient Records
- ☐ Other _____

Please check one:

- ☐ For dates of service from____/____/_____ to ___/____/_____
- ☐ For all dates of service

Reason for request:

- ☐ Permanently Changing Provider or Clinic (*Please specify reason)* _____
- ☐ Continuing Care
- ☐ Other (specify:*)* _____

As a courtesy, Eye Centers of Racine and Kenosha does not charge a copying fee if records are less than 15 pages. A reasonable copying fee, as permissible by state law, will be charged if records are ***more than*** *15 pages.*

To:
Eye Centers of Racine and Kenosha, Ltd.
☐ **9916 75th Street, Suite 101 Kenosha, WI 53142**
☐ **13200 Globe Drive, Suite 216 Mt. Pleasant, WI 53177**
Phone: (262) 637-0500 Fax: (262) 635-8027
From:

Name_____

Address_____

Phone Number_____

Fax Number: _____

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Deerfield Dermatology Associates, Ltd. You should contact the office manager to terminate this authorization.

Potential for Redisclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent.

_____

Signature of patient/Authorized Representative **Date**

Med Care West
9916 75th Street, Suite 101
Kenosha, WI 53142

Mt. Pleasant Commerce Center
13200 Globe Drive, Suite 216
Mt. Pleasant, WI 53177

Ph: (262) 637-0500 Fax: (262) 635-8027 Email: eyectr@amazingeye.com