A completed records release may be returned to Valley Eye (Attn: Linda) by any of the following methods:

* Mailed to 21 Park Place, Appleton, WI 54914
* Emailed to info@valleyeye.com
* Faxed to 920-739-6368

AUTHORIZATION FOR

RELEASE OF MEDICAL RECORDS

Patient Name_____ D.O.B_____

Former Name (if applicable)_____

Address _____

Release records from:

_____
(Name)

_____
(Address)

_____
(City, State, Zip)

_____
(Fax Number)

Release records to:

Valley Eye Associates:

☐ 21 Park Place
Appleton, WI 54914

☐ 2100 S. Kensington Dr.
Appleton, WI 54915

☐ 719 Doctors Crt.
Oshkosh, WI 54901

☐ 2500 E. Capitol Dr. Suite 3500
Appleton, WI 54911

Type of information to be released: Medical Records

Purpose or need for release:_____

This authorization will be effective for medical records generated to the date of signature.

I understand I may revoke this authorization at any time by providing my written revocation.

_____ _____
(Signature) (Date)

If patient is 18 or over, this MUST be signed by the patient. If signed by person other than patient, state relationship to patient and/or attach copy of P.O.A

Patient is: ___ A Minor ___ Incompetent ___ Deceased
Legal Authority: ___ Parent/Legal Guardian ___ Next of Kin of deceased or Personal Representative

FOR OFFICE USE ONLY: Records released on _____ by _____

02/14