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 549154
- Emailed to info@valleyeye.com
- Faxed to 920-739-6368

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name		D.O.B		
Former Name (if ap	plicable)			
Address				
Release records <u>from</u> :		Release records <u>to</u> :		
Valley Eye Associat 21 Park Place Appleton, WI		(Doctor of Clinic	c)	
2100 S. Kensington Dr. Appleton, WI 54915		(Street Address)		
719 Doctors Crt. Oshkosh, WI 54901		(City, State, Zip)		
2500 E. Capitol Dr. Suite 3500 Appleton, WI 54911				
Oshkosh, WI 54901		(Fax Number)	(Fax Number)	
Type of information	n to be released: Medica	l Records		
Purpose or need fo	r release:			
This authorization v	vill be effective for med	ical records generated to	the date of signature.	
l understand I may	revoke this authorizatio	n at any time by providir	ng my written revocation.	
(Signature)			(Date)	
•	•	d by the patient. If signe or attach copy of P.O.A.	ed by person other than	
Patient is:	A Minor	Incompetent	Deceased	
		t of Kin of deceased or sonal Representative		
FOR OFFICE USE ON	NLY: Records released or			