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:

**Valley Eye Associates:**

- ☐ 21 Park Place, Appleton, WI 54914
- ☐ 2100 S. Kensington Dr., Appleton, WI 54915
- ☐ 719 Doctors Court, Oshkosh, WI 54901
- ☐ 2500 E. Capitol Dr. Suite 3500, Appleton, WI 54911
- ☐ 358 S. Koeller Street, Oshkosh, WI 54901
- ☐ 1543 Park Place Suite 400, Green Bay, WI 54304

Release records to:

_____
(Doctor of Clinic)

_____
(Street Address)

_____
(City, State, Zip)

_____
(Phone Number)

_____
(Fax Number)

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 _____