Records Request Form

Date: ____/____/_______

Patient Name: ____ Date of Birth: ____/____/______

I hereby authorize Dr. ____, located at ______________________________

____

to furnish any and all information including but not limited to visual fields, OOR reports, MRI/CT/X-ray results, special testing results, mental health records, drug and/or alcohol abuse records protected by state law, and/or HIV test results, if any (except as specifically excluded below) to:

Cheyenne Eye Clinic
1300 E. 20th St
Cheyenne, WY 82001

Phone: 307-634-2020
Fax: 307-635-6510

Information excluded: ____

____

____

This authorization is effective now and will remain in effect until: ____/_____/______.

I understand that I may receive a copy of this authorization.

Signature of patient: ____ Date: ____/____/_____

If signed by person other than patient, please include your relationship to the patient:

- ☐ Parent or legal guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary of personal representative of a deceased patient

Witness signature: ____ Date: ____/____/_____

For Office Use Only

☐ Faxed   Signature: _______________________________________

☐ Mailed   Date: ____/____/_____

1300 E. 20th St. | 307-634-2020 | 307-635-6510 fax | cheyenneeyeclinic.com

Anne Miller, MD | David Smits, MD | Cullen Ryburn, MD | Brittney Statler, MD | Matthew Asano, MD
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