LAKES Eye Clinic
308 5th Ave South, Suite 110
Cold Spring, MN 56320
(p) 320-685-5400

Date: _____

Patient Name: _____
Date of Birth: _____

AUTHORIZATION TO SHARE HEALTH CARE INFORMATION

I, _____, authorize LAKES Eye Clinic to share my:

____ Appointment Details ____ Medical Information
____ Medical/Surgical Information ____ Billing/Financial information

____ **All Information Stated Above**

Please list all individual(s) name(s) and relationship(s):

_____

_____

_____

If you sign this authorization, you can revoke it at any time. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, please send us a written or electronic notice to LAKES Eye Clinic, telling us that your authorization is revoked.

Patient/Parent/Legal Guardian Signature:

_____

Authorized Representative Signature:

_____

Reason patient is unable to sign: