CHRISTENSON VISION CARE
2215 Vine Street, Suite E • Hudson, WI 54016
PHONE: (715) 381-1234 • (800) 428-2399
FAX: (715) 381-5357
EMAIL: info@christensonvisioncare.com

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

(Check One)
[ ] **Release** - Releasing information from CVC to you or your provider
[ ] **Request** - Requesting information from another provider to CVC

Patient Name: _____ **Date of Birth**: _____
Street Address: _____
City, State, Zip: _____ **Phone #**: _____

I authorize Christenson Vision Care to **OBTAIN** my medical records **FROM**:

_____
Name of Physician or Facility

_____
Street Address

_____
City, State, Zip

_____ / _____
Phone & Fax #

I authorize Christenson Vision Care to **SEND** my medical records **TO**:

_____
Name of Physician or Facility

_____
Street Address

_____
City, State, Zip

_____ / _____
Phone & Fax #

(Check One)
[ ] Include All Records
[ ] Include Only Records Between The Dates Of _____ And _____
[ ] Include Only Detailed Information As Follows:

_____

X _____ **Date:** _____
Signature of patient or patient's authorized representative

Relationship of representative (check one) ☐ Parent ☐ Legal Guardian or Executor (include copy of appointment)

For Office Use Only
Release Date/Initials: _____ / _____ ☐Mailed ☐Faxed ☐By Patient