2215 Vine Street, STE E1 * Hudson, WI 54016
PHONE: (715) 381-1234 * FAX: (715) 381-5357
E-Mail: info@christensonvisiontherapy.com

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Patient's Name:_____ **DOB:**_____/_____/_____

Street Address:_____

City, State, Zip:_____ **Phone:** (_____)_____- _____

*I Authorize Christenson Vision Therapy Center to **SEND** my Records **TO:***

_____ _____
Name of Physician or Facility Attention To

_____
Street Address

_____
City, State, Zip Code

_____ _____
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 [ ] Parent [ ] Legal Guardian or Executor

OFFICE USE ONLY

Records Sent _____/_____ [ ] Mailed [ ] Faxed [ ] By Patient
Date Initials

Records Sent _____/_____ [ ] Mailed [ ] Faxed [ ] By Patient
Date Initials