McCannel Eye Surgery
3124 West 70th Street
Edina, MN 55435
Phone (952) 848-8338 / Fax (952) 848-8302

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient name: _____ DOB: _____

Address: _____

Phone: _____ Cell: _____

I authorize McCannel Eye Surgery to request my medical records FROM:

_____

_____

I authorize McCannel Eye Surgery to release my medical records TO:

_____

_____

The following information is to be released (check appropriate boxes):

- ☐ Office notes
- ☐ Lab tests
- ☐ Other: _____

For the following dates of treatment:
From: _____ To: _____

I am requesting this information be released for the following reason:

- □ Continuation of care
- □ Attorney review
- □ Personal use (please enclose $0.75 + tax per page payment; $20 max.)
- □ Other: _____

- ❖ I understand that once information is released pursuant to this authorization, McCannel Eye Surgery cannot prevent the re-disclosure of this information to another third party.
- ❖ Except for research related treatment, McCannel Eye Surgery will not condition treatment on my signing of this authorization.
- ❖ I understand there may be a retrieval and copy charge associated with this release.

I understand that I may revoke this authorization by sending a written request for revocation to: Mary Owles, 3124 West 70th Street, Edina, MN 55435. If I revoke this authorization, McCannel Eye Surgery will no longer use or disclose my information for the reasons covered by this authorization except to the extent it has already relied upon this authorization.

This authorization shall expire one year from the date signed.

I understand and agree to the terms of this authorization:

_____

Patient or patient representative signature

_____

Date

If signed by a patient representative, state authority to act on behalf of the patient:

_____