# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**Melissa Tada, OD**
**Staci McMullen, OD**

6071 E. Woodmen Rd., Suite 205
Colorado Springs, CO 80923

Phone: 719-380-6808
Fax: 719-380-5656

Patient Name ____________________________________________________

Street Address ____________________________________________________

City __________________________ State ______ Zip ___________

Date of Birth ____________________________________________________

I authorize the release of my medical/vision records from:

Health Provider/Organization __________________________________________

City _____________________________ State ____________________________

Please send copies of all chart notes, photographs, optomap images, visual field tests, nerve fiber layer analysis results and any other pertinent medical information (including but not limited to, medical diagnosis and prognosis and treatment in the past or planned for the future) to:

**Mountain View Vision**
6071 E. Woodmen Rd., Suite 205
Colorado Springs, CO 80923
Fax: 719-380-5656

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**YOUR RIGHTS REGARDING THIS AUTHORIZATION**

I understand the following:

- I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed.
- I have right to receive a copy of this form.
- I am under no obligation to sign this form. Mountain View Vision will not condition treatment or payment on this authorization.
- Written notification is necessary to cancel this authorization. My withdrawal will not be effective to uses and/or disclosures of my health information that have already been made in reference to this authorization.
- This authorization is effective for one (1) year from the date signed unless otherwise indicated: ______

____________________________________________________________ ________________________
Signature of Patient or Legal Guardian Signature/Relationship Date

____________________________________________________________ ________________________
Witness Date