MUELLER VISION

LASIK & CATARACT EYE SURGERY

BRETT MUELLER, D.O., Ph.D. | TAJ NASSER, M.D. | REBECCA MILLER, O.D.

Patient Medical Records Release Form

I do hereby consent and authorize my medical records to be released.

Patient Name: ____ Date of Birth: ____________________

Address: ____

City: ____ State: ________ Zip: ______________

Phone: ___________________ Email: _______________________________ SSN# ______________

This information is to be released **TO**:

____

____

____

City State Zip

__________________________ __________________________

Phone Fax

This information is to be released **FROM**:

____

____

____

City State Zip

__________________________ __________________________

Phone Fax

Information being requested:

- ☐ Complete Record
- ☐ Records of care from the following dates: ____________ to ____________

State statute requires special permission to release otherwise privileged information. Please check applicable categories for release of records.

- ☐ Mental Health
- ☐ Developmental disabilities
- ☐ AIDS related diagnosis
- ☐ Alcoholism
- ☐ AIDS test results
- ☐ Drug abuse

Purpose or need for disclosure:

- ☐ Further medical care
- ☐ Payment of ins claim
- ☐ Vocational rehab eval
- ☐ Legal investigation
- ☐ Application for insurance
- ☐ Disability determination.
- ☐ Personal
- ☐ Other

Patient Signature: ____ Date: __________________

Signature of Legal Representative: ____________________________________ Date: __________________

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