MEDICAL EYE SPECIALISTS

300 NORTH WILLSON AVENUE, SUITE 1003
BOZEMAN, MT 59715-3551
406-587-1245

422 SOUTH MAIN ST.
LIVINGSTON, MT 59047
406-222-3323

205 W. MAIN ST.
BELGRADE, MT. 59714
406-388-2440

PATRICIA A. COSGROVE, M.D., M.P.H.
LISA A. HERRYGERS, M.D.
WESLEY H. ADAMS, M.D.
KRISTY L. MOELLER, M.D.
STEWART J. HAZEL, M.D.
JOSEPH P. SHEEHAN, M.D., M.S.

TO:

_____

_____

_____

RETURN TO:

TOLL FREE: 800-713-2086

MEDICAL EYE SPECIALISTS
300 North Willson, Ste. 1003
Bozeman, MT 59715

FAX: 406-587-1092

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Patient: _____ Date of Birth: _____

Social Security No: _____

_____ I request and authorize to release to Medical Eye Specialists the specified information.

_____ I authorize Medical Eye Specialists to release to you the specified information.

INFORMATION TO BE RELEASED. PLEASE CHECK ALL THAT APPLY

_____ Medical Records

_____ Operative reports

_____ Laboratory reports

_____ Radiology Reports

_____ H & P Reports

_____ Photos & Visual Fields

_____ Other: _____

I hereby consent to the release of any and all records containing Alcohol/Drug Abuse/HIV/Psychiatric diagnoses under the same consideration as above. I understand that such information cannot be released without my specific consent, except under a Court Order. It is my intent that information released is prohibited for any other purpose than that which is stated above.

_____ _____
Patient Signature/Approval Date

_____ _____
* Parent/Guardian Signature/Approval Date

_____ _____
Medical Eye Specialist' Representative Date

*If patient is a minor, signature of a parent or guardian is required.