WYOMING
EYE SURGEONS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

DOCTOR INFORMATION

To: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____

I hereby authorize and request you to release any and all information which you may possess relating to my examinations and illnesses, including psychiatric and/or psychological information and information pertaining to AIDS and/or Human Immunodeficiency Virus testing which may be a part of my medical records.

These records are to be forwarded to:

Wyoming Eye Surgeons
Dr. Michael Walker
36 N Gould St., Suite 201
Sheridan, WY 82801
(307) 429-0430 / Fax (307) 461-4386

Patient Signature: _____ Date: _____

Witness: _____ Date: _____