Drs. North & Watson Optometrists, P.A.

☐ Bloomington Office (304 N. Garden, Bloomington MN 55425; 952-858-8416)
☐ Burnsville Office (2070-72 Burnsville Center, Burnsville 55306; 952-435-3074)
☐ Ridgedale Office (12513 Wayzata Blvd., Minnetonka, 55305; 952-591-1972)
☐ Roseville Office (2480 Fairview Ave. N. Roseville, 55113; 651-633-9135)

Authorization for Release of Information

This form, when completed and signed by you, authorizes Drs. North and Watson Optometrists, P.A., to release protected information from your record to the person you designate.

Patient Information:

Name: _____ Phone #_____

DOB: _____ Exam Date _____

Release/Request:

I, _____, authorize Drs. North and Watson Optometrists, P.A., to release or obtain information with the following agencies or persons.

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone #_____ Phone #_____

Fax #_____ Fax #_____

Expiration:

This authorization expires on the following date, event or condition _____. If I do not specify any expiration date, event or condition, this authorization will expire in one year.

Statement of Authorization:

- I understand that, Drs. North and Watson will not refuse my treatment, payment, enrollment, or eligibility for benefits on my signing this authorization.
- Except to the extent that action has already been taken, I understand that I may revoke this authorization at any time by giving written notification to Drs. North and Watson. A photocopy/fax of this authorization will be treated in the same manner as the original.
- I do not authorize further release to any third party. I understand that once information is release as specified in this authorization, the facility, their employees and my physician(s) cannot prevent the re-disclosure of that information. I hereby release each of them from any and all liability arising directly or indirectly from disclosure authorized by this consent and any re-disclosure of that information.

_____ _____

Signature of Patient (or patient's personal representative) Date

_____ _____

Printed name of patient representative Representative's authority to sign for patient, (ie parent, guardian, power of attorney for healthcare, executor)