ALEX Vision Source®

2210 Highway 29 South, Suite 201
Alexandria, MN 56401

Office 320-219-6543 Fax 320-219-6545

AUTHORIZATION FOR RELEASE OF INFORMATION

RE:_____ DOB:_____

I authorize:_____
(Name of Facility)

_____
(City, State, Zip)

_____ _____
(Telephone) (Fax)

to release to Alex Vision Source information from the medical record maintained while I was a patient at your facility. I understand that I may revoke this authorization at any time and without an express revocation. It will expire after six months from the date of signature.

_____ _____
Date Signature of Patient, Parent or Guardian