Dr. Kristel Schamber
7734 Excelsior Road North
Baxter, MN 56425
Office: 218.829.2929 Fax: 218.829.4747

AUTHORIZATION FOR RELEASE OF INFORMATION

RE: ____ DOB: ______________

I authorize: ____

(Name of Facility)

to release to Lakes Area Eyecare 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