Daniel C. Satterlund, O.D.

FAMILY EYE CLINIC

120 Keller Ave. Amery, Wisconsin, 54001
304 First Street Luck, Wisconsin, 54853
715-268-9010 715-472-8875

(Last Name) (First Name) (MI) (Birthdate)

(Street Address) (City, State, & zip code)

(Maiden /Previous Name) (Medical Record #)

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS PRODUCED BY:

(Name of Physician)

(Name of Facility)

(Street Address) (City, State, & Zip Code)

RELEASE RECORDS TO:

(Name of Physician)

(Name of Facility)

(Street Address) (City, State, & Zip Code)

INFORMATION TO BE REQUESTED:

--ALL EYE RECORDS
--CONTACT LENS RECORDS
--LEGAL INVESTIGATION
--OTHER (PLEASE SPECIFY)

DATES OF SERVICES

FROM:_____ TO:_____

PURPOSE OR NEED FOR DISCLOSURE:

--FURTHER MEDICAL CARE
--DISABILITY DETERMINATION
--PHOTOS
--OTHER (PLEASE SPECIFY)

PLEASE CHECK ON OF THE FOLLOWING:

--PLEASE KEEP MY RECORDS ACTIVE
--PLEASE DELETE MY RECORDS FROM YOUR FILE

AUTHORIZATION WILL REMAIN IN EFFECT FOR ONE YEAR FROM DATE SIGNED. AUTHORIZE RELEASE OF MY RECORDS IN ACCORDANCE WITH THE SPECIFICATIONS LISTED ABOVE. I UNDERSTAND WRITTEN NOTIFICATION IS NECESSARY TO CANCEL THIS REQUEST.

SIGNATURE OF PARENT OR LEGAL GUARDIAN (IF PATIENT IS NOT OVER 18 YEARS)