

John C. Metzger, OD
Vision Therapy, Low Vision Rehabilitation & Neuro-Optometry

Ph: (913) 469-8686 • Fx: (913) 469-8688
10875 Grandview Drive, Suite 2260 • Overland Park, KS 66210

MEDICAL RECORDS RELEASE

Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Authorize and Request _____

Release to: John Metzger, O.D., 10875 Grandview Drive, Suite 2260, Overland Park KS 66210

Phone: (913) 469.8686

Fax: (913)469-8688

Name of Facility: _____

Address _____

City/State/Zip _____

Phone/Fax _____

Information to be released:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> All Clinic records | <input type="checkbox"/> Visual Fields | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Eye Records | <input type="checkbox"/> X-Ray, CT, MRI Reports | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> X-Ray, CT, MRI Films | <input type="checkbox"/> Other _____ |

I authorize release of my medical records in accordance with the specifications listed above.

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Dr. John C. Metzger.

Patients signature _____ Date _____

(If signed by person other than patient, state relationship and authorization to do so.)

Authorized signature _____ Date _____

Relationship to Patient _____

Patient is: Minor Incompetent Disabled Deceased

Legal Authority: Legal Legal Guardian Next of kin of deceased

- Information disclosed as requested in this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA rule
 - Treatment may not be conditioned on signing this authorization unless treatment is research related and the authorization is for use or disclosure for such research.
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