

**Schmidt EyeCare, LLC**

**Kimberly Schmidt, OD**

333 S. State Street, Suite T  
Lake Oswego, OR 97034  
Phone: (503) 636-2762 Fax: (503) 636-4502

**Authorization to release Medical Information:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_

<u>At my request, I Authorize:</u>	<u>To release my records to:</u>
Name: _____	Name: <u>SCHMIDT EYECARE</u>
Address: _____	Address: <u>333 S. State St. Suite T</u>
_____	<u>Lake Oswego, OR 97034</u>
Phone: _____	Phone: <u>(503) 636-2762</u>
Fax: _____	Fax: <u>(503) 636-4502</u>

Specifically, I authorize the use or disclosure of the following information:

\_\_\_ Complete records                      \_\_\_ Contact lens order

\_\_\_ Surgery records                      \_\_\_ Diagnostic tests

\_\_\_ Other: \_\_\_\_\_

Signature of Patient/Patient Representative: \_\_\_\_\_

Print Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date signed: \_\_\_\_\_

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