MILE HIGH EYE INSTITUTE

William Richheimer, MD
Zachary Vest, MD
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180 E Hampden Ave, Ste 200
Englewood, CO 80113
303.482.1300
www.milehigheyeinstitute.com

AUTHORIZATION FOR REQUEST OF RECORDS

*****To be completed if you have seen another ophthalmologist or doctor previously for reasons related to your visit with us. If you have not been evaluated by another practitioner for your current or a related condition/complaint, you may disregard this form.**

Name: ______________________ Date of Birth: ______________

Address: ______________________ Home Phone: ______________

City: __________ State: _____ Zip: ________ Cell Phone: ______________

Social Security No: ______________________ Work Phone: ______________

I authorize ______________________ **(name of doctor with present records)**

Address: ______________________ Phone: ______________

City: __________ State: _____ Zip: ________ Fax: ______________

to furnish medical information concerning the above-named patient to:

Mile High Eye Institute
3535 River Point Parkway, Suite 200, Sheridan, Co. 80110
Phone: 303-482-1300 Fax: 303-482-1356

I authorize the release of (select one of the following):

☐ Entire Record

☐ Medical Record limited to the following:

____

The above-named institution may use the information authorized only for the following purposes:

____ **(specify)**

The further use or disclosure of the authorized information by the above-named persons and institutions may not be accomplished without my further written consent.

This authorization shall become effective immediately and shall be valid until ______________, unless expressly revoked by me. **(Date)**

______________________________ ______________
Signature of patient or Authorized Patient Representative **Date**

______________________________ ______________
Signature of Witness **Date**