MILE HIGH
EYE INSTITUTE

William Richheimer, MD
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3535 River Point Parkway,
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AUTHORIZATION FOR RELEASE OF RECORDS

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City: _____ State: _____Zip: _____ Cell Phone: _____

Social Security No: _____ Work Phone: _____

I, the undersigned, authorize
Mile High Eye Institute
3535 River point Pkwy Sheridan, CO 80110
Phone: 303-482-1300 Fax: 303-482-1356

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

(Name of Doctor/Office) _____

Address: _____ Phone: _____

City: _____ State: _____Zip: _____ Fax: _____

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**