James A. Boucher, OD Sue E. Lowe, OD Gary M. Poteet, OD Amy E. Aldrich, OD

www.snowyrangevision.com

405 S 30th, Laramie, WY 82070 307-742-2020 800-480-2023 Fax: 307-742-8917

**CONSENT FOR RELEASE OF INFORMATION OR CLINICAL RECORDS**

Patient Name: ___________________________________ Date of Birth: ________________

I hereby authorize disclosure of records and or clinical information obtained in the course of my diagnosis and treatment:

**Please check all that apply.**

| | |
|---|---|
| To_____ From_____ | To_____ From____ |
| Name ______________________ | ___________________________O.D. |
| At _________________________ | Snowy Range Vision Center |
| Address____________________ | 405 S 30th St. |
| City ________________________ | Laramie |
| State _______ Zip___________ | WY, 82070 |
| Phone________ Fax_________ | 307-742-2020 Fax 307-742-8917 |

This disclosure of records authorized herein is required for the following purposes:

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Please check one.

_______Date from: ________

_______Complete record

PLEASE READ CAREFULLY: I understand that my medical records are confidential. I understand that by signing this consent form I am allowing my medical information to be released. I also understand that I may revoke this consent by written request at any time. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

Date: ______________________ Signature: ______________________________________

(Parent or Guardian if a minor)