Snowy Range Vision Center

Sue E. Lowe, O.D.
Gary M. Poteet, O.D.
Amy A. Lytle, O.D.

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:		☐ Dr. Lowe	☐ Dr. Poteet ☐ Dr. Lytle
Company:			
Address:		Snowy Range Vision Center	
City:		405 S 30th St.	
State:	Zip:	Laramie, WY 82070	
Phone: ( )		Phone: (307) 742-2020	
Fax: ( )		Fax: (307) 742-8917	

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

_____

Please check one: ☐ Last 2 Years
☐ Specific records/dates: _____

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 and that this form will remain valid until such consent is revoked. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

Print Name: _____

Signature: _____ Date: _____
(Parent or Guardian if a minor)