EDINA EYE
A DIVISION OF TWIN CITIES EYE CONSULTANTS

Edina Eye Physicians and Surgeons
7450 France Ave S, Ste 100
Edina, MN 55435
Tel: 952-832-8100
Fax: 952-832-8188

MEDICAL RECORDS REQUEST AND AUTHORIZATION FORM

Print Patient full name	
Date of birth	
Address	
Phone	

1. **I hereby request and authorize_____ to release my medical records to Edina Eye Physicians and Surgeons.**

_____ Specific date of service _____

_____ All records*

Method of delivery: choose one.

_____ Mail to: Edina Eye Physicians and Surgeons
7450 France Ave S, Ste 100
Edina, MN 55435
Attention: Medical Records

_____ Fax to: 952-832-8188

2. **I authorize Edina Eye Physicians and Surgeons to release the following records:**

_____ Specific date of service _____

_____ All records*

Method of delivery: choose one.

_____ Mail to: _____

_____

_____

_____ Fax to: _____

_____ _____

Patient/Legal Representative Signature **Date**

*Please note, indicating “All records” will include any records from previous providers which may include HIV/AIDS status, cancer diagnosis, mental health records, drug/alcohol abuse, sexually transmitted disease, and other medical history information. You are hereby authorizing disclosure of all information within your record.