Helena Eye Clinic

3116 Saddle Drive, Suite 3
Helena, MT 59601
Office: 406 443 4040
Fax: 406 443 0773

I, _____ _____,
Patient Name Date of Birth

hereby request that:_____
(Doctor or Clinic Name)

_____
Phone Fax Address

provide in writing to: _____

_____
Phone Fax Address

A report of my diagnosis, treatment, prognosis and recommendations as well as other data pertinent to his treatment of me during the period I was in his care. I understand that many systemic diseases may affect my vision. I give express consent to release any health care information relating to testing diagnosis and/ or treatment for HIV (AIDS virus), sexually transmitted diseases psychiatric disorders/mental health, or drug and/or alcohol use.
This release will expire 30 months from the date signed.

Please mark one:

Moving ____ Referral ____ Transferring Care ____ Other _____

_____ _____
Patient Signature Witness Signature

_____
Date