KENNEDY
VISION HEALTH CENTER

10600 OLD COUNTY ROAD 15 ● PLYMOUTH, MN 55441 ● (763) 545-8850
9075 QUANTRELLE AVE NE ● OTSEGO, MN 55330 ● (763) 441-0205

Medical Records Release

Patient Name:_____
DOB:_____Phone:_____
Address:_____
City:_____State/Zip:_____

I am requesting information sent to/from:

_____
Fax:_____ Date:_____

Send Records To/From:

Kennedy Vision Health Center

☐ 10600 Old County Road 15
Plymouth MN 55441
Fax: 763-544-1257

☐ 9075 Quantrelle Ave NE
Otsego MN 55330
Fax: 763-441-7631

Records Requested:

____Eye Exam including contact lens information
____Consultation / Follow-up Reports
____Cataract / Glaucoma / Retina Care
____School Records
____ Special Reports
____ All Information

Request Reason:

_____Insurance Change
_____Personal
____Consult / Second Opinion
____Other
_____Moving
_____Legal

Release: I authorize my complete records concerning the medical/educational findings and I release the professional named of any laws related to disclosure of confidential or privileged information. I understand that this authorization will be in effect until I cancel the request in writing.

Signature:_____ Date:_____