Jaren Olsen, OD
3508 S 25th E, Idaho Falls, ID 83404
Phone: (208) 557-3222
Fax: (208) 561-8692

Record Request Form

Patient Information:

Full Name: _____

Date of Birth: _____

Phone Number: _____

Authorization to Release Health Records

I, the undersigned, hereby authorize Reframed Eye to request the medical records including complete eye exam records, glasses prescriptions, and contact lens prescriptions from:

Practice/provider name: _____

Fax Number: _____

Patient's Right to Copy

I understand that I have the right to receive a copy of this authorization form after signing it.

Confidentiality Notice

The information released will be kept confidential and will only be shared with Reframed Eye. This disclosure may include sensitive health information.

Signature of Patient or Legal Guardian

I acknowledge that I have read and understand the information provided on this form, and I authorize the release of my health records as described.

Patient Signature: _____

Date: _____

If signing as a legal guardian or representative:

Name of Representative: _____

Relationship to Patient: _____

Signature of Representative: _____

Date: _____