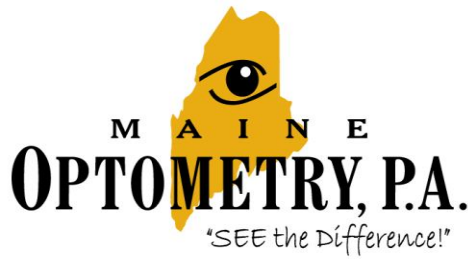


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Rachel L. Achenbach, O.D.
Ryan M. Carr, O.D.

Authorization to Release or Obtain Healthcare Information

Patient Name: _____ DOB: _____

Responsible Party: _____ Relationship to patient: _____

Release Records TO:	Obtain Records FROM:
Physician/ Institution:	Physician/ Institution:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Fax:	Fax:

This request and authorization applies to (check all that apply):

All health information:

Specific health information relating to the following treatment, condition or dates:

Other:

Doctor reviewed/ approved: _____ Date: _____

_____ Date: _____

(Patient/ Parent/ Legal Representative Signature)

THIS AUTHORIZATION IS VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE