

John C. Metzger, OD
Vision Therapy and Low Vision Rehabilitation

Ph 913-469-8686 • Fax 913-469-8688
11248 Strang Line Rd. • Lenexa, KS 66215

MEDICAL RECORDS RELEASE

Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Authorize and Request _____

Release to: John Metzger, O.D., 11248 Strang Line Road, Lenexa KS 66215

Phone 913.469.8686

Fax 913.469.8688

Name of Physician/Facility: _____

Address _____

City/State/Zip _____

Phone/Fax _____

Information to be released:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> All Clinic records | <input type="checkbox"/> Visual Fields | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Eye Records | <input type="checkbox"/> X-Ray, CT, MRI Reports | <input type="checkbox"/> Office Notes |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> X-Ray, CT, MRI Films | <input type="checkbox"/> Other _____ |

I authorize release of my medical records in accordance with the specifications listed above.
I understand that this authorization shall be valid for one (1) year unless otherwise stated below
or revoked through written notice to Dr. John Metzger.

Patients signature _____ Date _____

(If signed by person other than patient, state relationship and authorization to do so.)

Authorized signature _____ Date _____

Relationship to Patient _____

Patient is: Minor Incompetent Disabled Deceased

Legal Authority: Legal Legal Guardian Next of kin of deceased

- Information disclosed as requested in this authorization may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA rule
- Treatment may not be conditioned on signing this authorization unless treatment is research related and the authorization is for use or disclosure for such research.
