CENTRAL ILLINOIS EYECARE, L.L.C.
Eric Norell, O.D.
Michelle R. Willenbring, O.D.
---------- Tom Mahaffey, O.D. ----------
407 Kays Drive Suite A, Normal, Illinois 61761
Phone: (309) 454-1010 * Fax: (309) 454-1077

MEDICAL RECORDS RELEASE AUTHORIZATION

TO:
DOCTOR_____ **FAX #:** _____

ADDRESS_____

CITY, STATE, ZIP_____

I hereby authorize and request the office of Drs. Norell, Willenbring, & Mahaffey, at the address listed above, to...

- ❑ ***Release*** the following medical information.
- ❑ ***Obtain*** the following medical information.

❑ Complete Records ❑ Spectacle and/or Contact Lens Information

❑ Other_____

Special Dates of Interest_____ to_____

****

I, _____, understand that my expressed consent is required to release any health information relating to testing, diagnosis, and/or treatment. You are specifically authorized to release all such healthcare information.

Patient Name_____ D.O.B._____

Address_____

City, State, Zip_____

Signature_____ Date_____

Witness_____