Peter S. Foote, M.D. Aaron C. Holtebeck, M.D.ArvindSaini, M.D.Robin S. Wilson, M.D.

Jay A. Heilmann, O.D.Megan E. Lind, O.D.Michelle H. Pedersen, O.D.Charles T. Ries, O.D.David J. Weis, O.D.

Medical Authorization Release Form

☐ No, I do not want my healthcare records shared.

☐ Yes, I authorize the staff and physicians of Milwaukee Eye Care Associates, S. C. to discuss my personal healthcare information, treatment and/or billing deemed pertinent tomy health care with the following persons:

____

Name Relationship Phone Number

____

Name Relationship Phone Number

____

Name Relationship Phone Number

This request shall remain in effect until such date that I inform the staff of my desire to makechanges to this document or cancel this document.

____

Patient Name (print)

______________________________ ______________________________

PatientSignature Date

(414) 271 – 2020

www.milwaukeeeyecare.com

1684 N. Prospect Avenue, Milwaukee, WI 53202 17280 W. North Avenue, Suite 100, Brookfield, WI 53045

500 W. Brown Deer Road, Suite 110, Bayside, WI 53217 9200 W. Loomis Road, Suite 204, Franklin, WI 53132