



Comprehensive
Eye Care

Scott M. Buckingham, O.D., P.C.
John E. Kaminski, O.D., F.A.A.O.

Doctors of Optometry



Members American
Optometry Association

Date: _____

Patient: _____

Birthdate _____

Dear _____:

Please forward to our office a copy of the records checked below. Any other pertinent information that you could forward would be appreciated.

- Ophthalmoscopy/Biomicroscopy report
- Refraction History
- Tonometry pressures/Visual Fields reports
- Contact lens history/measurements
- Other: _____

Thank you for your cooperation.

Sincerely,

Scott M. Buckingham, O.D., P.C.
John E. Kaminski, O.D., F.A.A.O.

I hereby authorize _____ to transfer my vision care records (and any other information that deems relevant) to Dr. Scott Buckingham/Dr. John Kaminski.

Signed: _____ Date: _____
(FULL NAME)

Scott M. Buckingham, O.D., P.C.
John E. Kaminski, O.D., F.A.A.O.
1504 Harcrest Dr.
Midland, MI 48640
(989) 636-7580

I hereby authorize, Scott M. Buckingham, O.D., P.C., and/or
John E. Kaminski, O.D., F.A.A.O., to transfer/release my vision
care records and any other information that is relevant to:

Signed: _____
(full name)

Date: _____

Witness: _____

Date: _____

Scott M. Buckingham, O.D., P.C.
John E. Kaminski, O.D., F.A.A.O.
1504 Harcrest Dr., Suite 3
Midland, MI 48640

AUTHORIZATON TO RELEASE PROTECTED HEALTH INFORMATION

I, _____ authorize the office of
Dr. Scott M. Buckingham and Dr. John E. Kaminski to release my Protected
Health Information to the individual(s) listed below. I understand at any time
that I can change or revoke this authorization. I understand that only
minimal necessary information will be released to the individual(s) listed below.

Individual(s) that may have access to my Protected Health Information are:

_____ RELATIONSHIP _____
_____ RELATIONSHIP _____
_____ RELATIONSHIP _____

SIGNATURE OF PATIENT, GUARDIAN, OR
AUTHORIZED REPRESENTATIVE

Date: _____