MRN: _____
Office Use Only — Date/Initial
*** Rec'd by Clinic Rep: _____**
*** Faxed to Pt Doc Coord: _____**
*** Completed by Pt Doc Coord: _____**
*** Completed by Provider/Clinic:_____**
*** Sent to Pt Doc Coord (close): _____**
*** Scanned & sent to pt: _____**

EYE CENTER OF NORTHERN COLORADO
1725 E. Prospect Road Fort Collins, Co. 80525-1307
Phone: (970) 221-2222 Fax: (719) 996-5630
PECPatientCare@panoramaeyecare.com

PATIENT PAPERWORK COMPLETION/ LETTER REQUEST

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Contact Number(s): _____

Did or will you miss work/school/trip? Yes_____ No _____ Not Applicable_____

If so, what dates? _____

Reason work/school/trip was/will be missed: _____

Type of Form: (i.e., FMLA, insurance, disability, letter etc.) _____

How would you like to receive your form? (Select all that apply) __ Call me when ready to pick up at this number: _____

__ Mail to this address: _____ __ Email to this email address: _____

__ Fax to this number: _____ __ Other: _____

If picking up which location, would you like to pick up from: Prospect Precision Skyline

Centerra Fox Run

When do you need your form/letter? _____ Please note paperwork can take up to 1 week to complete.

Any additional information that we need to know? _____

Authorization for the Disclosure of Health Information

Information released from:

Eye Center of Northern Colorado
1725 E Prospect Rd
Fort Collins, CO 80525

Information to be released to:

Name of receiver: _____

Address:_____

_____

I hereby authorize the Eye Center of Northern Colorado, P.C. to obtain the specified information as stated in this authorization. I understand that the information in my health record may include information relating to sexually transmitted diseases, HIV/AIDS, mental health and drug or alcohol abuse. I hereby release the Eye Center of Northern Colorado, P.C. and its employees from any and all liability that may arise from the release of information as I have directed. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Without my express revocation, the authorization will automatically expire one year from the date of signature.

Patient Signature: _____ Date Signed: _____

Parent/Guardian Signature: _____ Date Signed: _____