**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: _____**




4745 Arapahoe Ave. Suite 100
Boulder, CO 80303
101 Erie Parkway, Suite 202,
Erie, CO 80516
Phone: (303) 444-3000 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: Arapahoe Erie

**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? _____**

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### Authorization for the Disclosure of Health Information

**Information released from:**

Boulder Eye Surgeons

4745 Arapahoe Ave. Suite 100
Boulder, CO 80303

101 Erie Parkway, Suite 202,
Erie, CO 80516

**Information to be released to:**

Name of receiver: _____

Address:_____

_____

I hereby authorize Boulder Eye Surgeons. 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 Boulder Eye Surgeons. 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: _____