First Name	Last Name	
Email Address:		
Date of Birth	Home Phone	Cell Phone
Street Address	City/State	Zip Code

I am requesting a copy of my health records that are maintained by Kueber Eye Care for my personal review. I am requesting records for date(s) of service: _____

How would you like your records delivered to you? Please indicate below:

☐ RevPHR

☐ Non-Secure Email*

☐ U.S. Mail (paper)

☐ Pick-up in person

☐ View Onsite (supervised)

***NOTE: I acknowledge that by selecting to receive my health information via email in a non-secure manner that the information will not be encrypted, and that it could be intercepted and viewed by a third party. Kueber Eye Care is not responsible for unauthorized access of your health information while in transmission to the email address you designated above.**

A patient will not be charged a fee for the first copy of the patient record buy may be charged for additional copies of the same record.

Please sign and date below

Patient Signature	Date
Signature of Personal Representative Relationship	Date

For Questions Call Kueber Eye Care at 218-732-8535.

Completed forms can be sent via:

Fax: 218-732-6957
Email: contact@kuebereyecare.com
Mail to: Kueber Eye Care
1011 1st Street East
Park Rapids, MN 56470