Authorization For Disclosure of Health Information

CATARACT & RETINA
LASER INSTITUTE

Patient Information

Name: ______________________ DOB: ______________________ Date: ______________

Address: ______________________ Phone: ______________________ Acct#: ______________

______________________ ______________________

I hereby request a copy of my medical records as detailed below. All records may take up to 14 business days.

OPTION 1 - Personal Use:

❒ **The *last complete exam* at NO CHARGE**

Pick Up – Office Location: ______________ ***OR*** Mail – Address: ______________________

OPTION 2 – Continuing Care/Other Health Care Provider:

Please forward my records to the following Health Care provider:

❒ **The *last three exams including testing* at NO CHARGE**

Provider Name / City, State: ____

Phone Number/Fax Number: ____

OPTION 3 – Select ONE:

For all options below, records will be charged at $1.00 per page for the first 25 pages and $0.25 for each additional page unless otherwise provided by law. I agree to pay this charge in full at the time I receive the copy of the record.

***Patient Initials:** ________________________*

Reason for Request: ____

❒ Full medical record held by this office

❒ Medical record for the period ___________________ through _____________________.

❒ A specific portion/section of the record as follows: ______________________________

Pick Up – Office Location: ______________ ***OR*** Mail – Address: ______________________

Consent For Release

I understand: I have the right to receive a copy of the health information which I've authorized to be used/disclosed through this document. There may be a charge for medical record copies. In addition, I do not need to sign this form in order to receive treatment. I may revoke this authorization by notifying the disclosing medical records/health information department in writing. However, my revocation will not be effective as to uses and/or disclosures:
(1) already made in reliance upon this authorization; or (2) the need for an insurer to file a claim/policy as authorized by law if signing the authorization may be a subject to re-disclosure and may no longer be protected by federal law.

I hereby authorize the following individual to pick up my medical records (Photo ID Required):______________________

Patient/Guardian Signature: ______________________________________ Date: ______________

If signed by a person other than the patient, please check the following:

1. Individual is: ❒A Minor ❒Legally Incapacitated or Incompetent ❒Deceased
2. Legal Authority: ❒Parent ❒Legal Guardian ❒Next of Kin/Executor of Deceased ❒Activated POA for Health Care

Witness (Print): ______________________________________ Date: ______________