Visionary Eye Doctors
Advanced technology with a loving touch

Authorization to Release Medical Records
Form Must Be Completed

Medical Records Copying Fee as of January 2019 policy for Visionary Eye Doctors

We keep medical records in electronic format and charge a fee of seventy nine $0.79 cents per page to copy medical records. You can choose to have your records faxed, mailed with the postage fee being an additional cost, or you may pick your records up at our office. *We do not e-mail records because that is not compliant with HIPAA regulations.* If you request your records to be released and sent to a provider, facility, lawyer or a person other than you (the patient or the patient's personal representative) we charge a preparation fee of $22.00 dollars, plus the $0.79 cents per page fee, and the postage fee cost. No copying fees and handling fees can be applied to any Medicaid patient.

PATIENT INFORMATION

PATIENT'S NAME: _____DATE OF BIRTH: _____
STREET ADDRESS: _____ CITY, STATE & ZIP CODE: _____

AUTHORIZATION TO:

- ☐ PICK UP SELF
- ☐ MAIL TO ADDRESS ABOVE (postage and shipping charges applicable)
- ☐ AUTHORIZATION OF _____TO PICK UP MY RECORDS. (PHOTO ID REQUIRED)
- ☐ FAX TO NAME _____OF HEALTH CARE PROVIDER |PLAN |ATTORNEY| OTHER| AT THIS FAX NUMBER _____
- ☐ MAIL TO HEALTH CARE PROVIDER | PLAN |ATTORNEY| OTHER AT THIS ADDRESS: _____
  _____

DATES OF INFORMATION TO BE RELEASED:

FROM: _____/_____ (MONTH/YEAR) TO: _____/_____(MONTH/YEAR)

☐ ENTIRE RECORD ☐ DIAGNOSTIC TESTING ONLY ☐ OTHER (SPECIFY: _____

REASON: PLEASE CHECK ALL THAT APPLY, PLEASE NOTE A COPY FEE OF $0.79 cents for each page applies, *as well as a preparation fee of $22.00 dollars, if the records are asked to be released and sent to a provider or a person other than the patient or the patient's personal representative*

- ☐ TRANSFER OF MEDICAL CARE
- ☐ LEGAL INVESTIGATION OR ACTION
- ☐ PERSONAL (AT MY REQUEST)
- ☐ INSURANCE
- ☐ OTHER (SPECIFY): _____

YOUR RIGHTS REGARDING THIS RELEASE OF MEDICAL INFORMATION:

- **I understand I may be charged a fee for record copies, not to exceed $81.63 dollars as well as the actual cost of postage and handling**
- By signing below, I acknowledge that: I may revoke this authorization in writing, but it will not affect disclosures/transfers already in progress made with this authorization
- I may refuse to sign this authorization, and my treatment may not be conditioned on my signing of this form, unless the purpose of my treatment is disclosure to a third party (for example, a drug test for employment) or needed for an insurer to contest a claim/policy as authorized by law if signing the authorization was a condition to obtaining insurance coverage
- I can receive a copy of this authorization upon request
- A photocopy or scanned image of this authorization may be used in lieu of the original
- I understand that recipients may not be subject to federal law and disclose information which I have authorized them to receive

SIGNATURE: _____ DATE: _____

IF SIGNED BY A PERSONAL REPRESENTATIVE OF PATIENT, PRINT NAME AND RELATIONSHIP TO THE PATIENT:

NAME: _____ RELATIONSHIP: _____