AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Visionary Eye Doctors
Advanced technology with a loving touch

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 _____ **(NAME OF PERSON PICKING UP)** 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:

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

YOUR RIGHTS REGARDING THIS RELEASE OF MEDICAL INFORMATION:

- 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: _____

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