AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Purpose: This form is used to confirm the direction of an individual to authorize Visionary Eye Doctors to request, to use, or to disclose the individual's health information.

PLEASE PRINT LEGIBLY; we are not able to process the incomplete or illegible forms.
Indicates mandatory fields

SECTION A: IDENTITY OF THE REQUESTOR OF INDIVIDUAL'S HEALTH INFORMATION (CHECK ONE)

- ☐ Patient
- ☐ Parent/ Guardian of Minor Child
- ☐ Parent/ Guardian authorized to consent to healthcare (Adult)
- ☐ Other: ______________________________________

Requestor: ____________________________________Phone: ____________________________________

Address: ____

Fax: _______________________ (Must be a secured fax machine)

SECTION B: PATIENT'S HEALTH INFORMATION AUTHORIZED FOR USE AND DISCLOSURE

*Last Name: _________________ *First Name: __________________ MI: ___ *Date of Birth: __________

*Street Address: ____ Apt #: __________

*City: ____ *State: _____________*Zip: _____________

Phone (home): ______________________________________ (mobile): _______________________

SECTION C: DISCLOSURE BEING AUTHORIZED

Our practice's standard policy is to disclose the patient's last visit records and all diagnostic testing done during that visit. If you wish to have more than the last visit, please indicate the date range here:

____

REASON FOR THE DISCLOSURE: PLEASE CHECK ALL THAT APPLY:

- ☐ Transfer of Medical Care
- ☐ Legal Investigation or Action
- ☐ Personal (At My Request)
- ☐ Insurance Eligibility/ Benefits
- ☐ Other (Specify): _________________________________

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SECTION D: REVOCATION

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Visionary Eye Doctors. To obtain a revocation form to revoke this authorization, I understand that I may contact Visionary Eye Doctors. I understand that revocation of this authorization will not affect any action that the Visionary Eye Doctors or others named or unnamed took in reliance on this authorization before Visionary Eye Doctors received my written notice of revocation.

SECTION E: SIGNATURE To the Individual – Please Read the Following: I authorize the disclosure of my health information as described in sections C and D above. I understand this authorization is voluntary. I understand that if the persons or organizations I authorize to receive and/or use my health information are not subject to federal or state health information privacy laws, they might further disclose the health information, and it may no longer be protected by the health information privacy laws. I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my intent.

Signature of Individual Requestor: ______________________________Date: _________________________

Printed Name of Individual Requestor: _____________________________

If a personal representative is making this request, please attach a copy of any document granting legal authority and complete the following:

Personal Representative's Name: ______________________________ Date: __________________________

Relationship to Individual: ______________________________________

To finalize this form, it must be faxed to (301) 896-0968 or mailed to 11300 Rockville Pike Suite 1202, Rockville, MD 20852, attention to Jennifer Flores, or brought into the office by the requestor. Our team will release the medical records within 3-5 business days after receiving this completed form.

Visionary Eye Doctors is prohibited from conditioning the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on the requirement that a person in interest sign the authorization.