Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SS#: _____ Patient's phone #: ( ) _____
Date of Request: _____ **Date Needed:** _____

I authorize Capital Eye Physicians & Surgeons, LLC **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

OR

I authorize Capital Eye Physicians & Surgeons, LLC **to obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one.) Healthcare Insurance coverage Personal Other
Transfer of Care

All medical records related to a specific illness or injury**.**

_____
Specify illness/injury Date(s) of treatment

Entire copy of the record checked above.

AUTHORIZATION VALID FOR: (Check one.)

This request only.

One year from the date of this authorization **OR** _____ . (Insert date.) This authorization applies to the records of the treatment received on or prior to the date of this authorization.

This request **and** for medical records of any **future** treatment of the type described above until: _____
Insert Date

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient *(if requester is not the patient)* _____