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Release of Medical Information

Patient Name (Print) Medical Record Number Patient DOB

I authorize Eye Surgical Associates to release my health information as described below.

To:

Address

From:

Address

Fax#: Phone#:

Please release only the following information:

- Please release my entire record
-OR-
Please release only the following information (check appropriate boxes and include other information where indicated):
Records from last years
Dr. Letter only-Date
OP Report Dates
Diagnostic Reports
Consultation reports (please supply doctors' names):
Other (please describe):

The identified information will be used for the following purpose:

- My personal records
Sharing with other health care providers as needed
Other (please describe):

Please initial each item below to indicate your understanding.

- I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
I understand once the information below is released, it may be re-released by the recipient and the information may not be protected by federal privacy laws or regulations.
I understand I have a right to stop this authorization at any time. I understand if I stop this authorization, I must do so in writing to the practice. I understand the stopping this form will not apply to information that has already been released. I understand that stopping will not apply to my insurance company when the law provides my insurance company with the right to contest a claim under my policy.
I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

Patient Signature (or Signature of Person Completing Form if Not Patient\*)Date

\*Relationship to patient: Parent Legal Guardian Other:

This Authorization expires one year from date signed.