Authorization for Use or Disclosure of Medical Record Information

Patient Information:

Patient Full Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____Zip: _____ Work/Cell Phone: _____

Release Information To:

I hereby Authorize Eye Care Medical Group Inc. to release my medical record information to:

☐Mail Copies To: ☐Hold for Patient Pick-up

Name/Facility: _____ Attention: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Purpose of Request: ☐ Personal ☐Continuing Care ☐Legal ☐ Other_____

Specific Information to be Released:

☐ All the records ***or***

☐ The portion of the records concerning:

_____

_____

_____

_____

The fee for copying medical records is $15, an additional $10 for all color printouts of Fundus photos, and an additional $5 for all color printouts of O.C.T. photos. If you have not been seen in our practice for over 2 years, the cost to obtain chart from storage is an additional $5.00. Processing fees are due at receipt of copies of records.

_____

Patient Signature **Date**

_____

Parent/Legal Health Care Representative Signature* **Date**

_____

Released by **Date**

***A copy of any Power of Attorney must be provided if requestor is POA**