CHRISTEN ALLAMAN, M.D.
EYE CARE MEDICAL GROUP, INC.

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**

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