HEALTHY EYES
FAMILY VISION CARE

Medical Records Release Form

Patient Name: _____ **Date of Birth:** _____

At my request, I authorize:

Practice Name _____

Address _____

_____

Phone _____ Fax _____

To disclose the following information:

- ☐ All medical records pertaining to the patient
- ☐ Other: _____

To be sent to:

Name/Institution _____

Address _____

_____

Phone _____ Fax _____

Purpose of the disclosure:

- ☐ Continuity of care
- ☐ At the request of the individual
- ☐ Other: _____

I understand that any disclosure of health information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal privacy rules.

I understand that I have the right to revoke this Authorization at any time, except to the extent action has been taken in response to this authorization, by giving written notice of revocation to the practice at the address noted above. I also understand that the revocation will not apply to my insurance company when the law provides any insurer with the right to contest a claim under my policy. (The written revocation must be legible and include the name and date of birth of the individual, the date the revocation is to go into effect, a description of the health information covered by the revocation, the person/entity no longer authorized to receive the information, the signature of the person with legal authority for authorization/revocation, and their phone number.)

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility of benefits.

Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below or on the following date, event, or condition.

I certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

_____ _____

Patient/Legal Guardian Signature Date