city of vision eye care

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

1. PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Patient Phone Number_____

2. INFORMATION TO BE RELEASED TO

Date Needed by _____ (allow 7-10 business days for processing)

Organization / Person _____

Select ONE of the following methods of delivery

◯ In Person Pick Up ◯ Fax ◯ Email ◯ Mail (mailing fees apply)

Address _____

City/State/Zip _____

Phone _____ Fax _____ Email _____

3. PURPOSE OF RELEASE

◯ Transfer of Care
◯ Copies for own use
◯ Insurance
◯ Legal / Disability
◯ Other _____

4. RECORDS TO BE RELEASED

Treatment Dates: From _____ To _____

◯ Prescription for Glasses / Contacts
◯ Clinical Exam Notes
◯ Optomap, OCT, Visual Fields
◯ Discharge Summary
◯ Other _____

5. MY RIGHTS / MY AUTHORIZATION

This consent is subject to revocation at any time except to the extent that the person who is to make the disclosure has already taken action in reliance on it. If you wish to revoke this authorization, you must do so in writing to the address at the top of this form, to the attention of the Director, Health Information Services. If not previously revoked, this consent will terminate one year from the date of signature. Failure to sign this form will not impact your right to receive care at City of Vision Eye Care. Neither our treatment nor your payment is conditioned upon your signature on this form. I hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated herein.

6. SIGNATURE

Signature of Patient or Legally Responsible Party _____ Date _____

Relationship to patient _____

STAFF USE ONLY	Date Completed:	Completed by: