MEDICAL RECORDS RELEASE FORM

ASSOCIATES IN EYECARE, P.C.
DISEASES AND SURGERY OF THE EYE

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Patient Name (print): _____ D.O.B.: _____/_____/_____

Phone: _____ E-mail: _____

*I, the undersigned, hereby authorize **Associates in Eyecare, P.C.** to (check all that apply)*

☐ **RELEASE** my protected health information to

☐ **OBTAIN** my protected health information from

Name of Person/Physician/Agency: _____

Address: _____

_____

Phone: _____ Fax or Email: _____

Please release:

☐ ALL records

☐ Records rendered during the period from ___/___/___ to ___/___/___

☐ Other (please specify): _____

I understand that I may revoke this consent at any time with the exception of records that have already been released and that any records received from another provider will not be disclosed. This consent with expire one year following the date of signature below.

Signature: _____ Date: _____/_____/_____

Relation to Patient: ☐ Self ☐ Other (please specify): _____

***PLEASE FILL OUT THIS THIS FORM COMPLETELY** AND ALLOW UP TO THIRTY BUSINESS DAYS FOR YOUR REQUEST TO BE PROCESSED. ANY ITEMS LEFT BLANK WILL DELAY THE RELEASE OF YOUR RECORDS.*