



# MEDICAL RECORDS RELEASE FORM

I do hereby consent and authorize Advanced Eye Care Center to release copies of my medical records.

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**DISCLOSE INFORMATION TO:**

Name/Facility \_\_\_\_\_  
Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

**PATIENT (Oneself)**

Y Email: \_\_\_\_\_ Y Fax: \_\_\_\_\_ Y Printed Copy-Pickup By: \_\_\_\_\_

**INFORMATION TO BE DISCLOSED:**

- Last Visit Notes
- All Billing Records
- All Records
- Last Eye Exam Records
- All Medical Records
- Other \_\_\_\_\_

**PURPOSE OF DISCLOSURE:**

- Continuing Medical Care
- Legal
- Other \_\_\_\_\_
- Insurance Claim
- Personal
- Out-of-town move
- Consult

**EXPIRATION DATE**

This authorization will expire one year from the date of signature at the bottom of this form.

**REVOCACTION**

I understand that I may revoke this authorization at any time by sending a written notice to the health care facility/provider noted above. However, the revocation is not valid if: (1) action was previously taken in reliance on this authorization, or (2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

**AUTHORIZATION**

I hereby authorize the above facility/provider to disclose medical information concerning the above-named patient to the party identified in the section entitled "Disclose Information To." I understand that the information to be released may include information regarding mental health, alcohol and drug usage, and HIV-related information. I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient and may no longer be protected. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits.

**Signature of Patient/Representative** \_\_\_\_\_ **Date** \_\_\_\_\_  
Relationship to Patient (if signed by representative) \_\_\_\_\_

Please provide proof of authority to act. For minors, proof is only required if other than parent.