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Athenaeyecare.com

ATHENA EYE CARE

ADVANCED OPHTHALMIC CARE

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Phone: _____ Email address: _____

Request release of information FROM:

Physician/Facility or Patient:

_____

Street Address: _____

City/State: _____

Phone: _____

Fax: _____

Request release of information TO:

Physician/Facility or Patient:

_____

Street Address: _____

City/State: _____

Phone: _____

Fax: _____

Please release the following information (check all that apply)

☐ Complete Medical Record

☐ Medical Records for Specific Dates of Service (please list):

From _____

To: _____

Reason for Release (check all that apply)

☐ Continuing medical/surgical care

☐ Insurance

☐ Relocating

☐ Other: _____

This authorization remains in effect no longer than one year from the date of signature or until the following date or event:

_____

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPAA). I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____

Name of Patient or Authorized Representative Date

_____

Signature of Patient or Authorized Representative