AUTHORIZATION FOR RELEASE OF PROTECTED OR PRIVILEGED HEALTH INFORMATION (RELEASE OF MEDICAL RECORDS)

*****We will begin to process your medical record request after we have received back this form completed, with your signature. The normal processing time is 1 week.**

PATIENT NAME: _____, _____ PATIENT D.O.B. _____

PATIENT'S ADDRESS: _____

_____

TELEPHONE NO: _____ _____

I, _____, do hereby authorize Retina Eye Care, P.C., to release my protected health information including copies of my medical record of care to the following person at the locations/facilities listed below, for the purpose described:

Person(s)/Facility/Address
(Include name and address and phone #)

_____
_____
_____
_____
Phone # _____

☐ I would like to pick up my records. please call me when completed.
I understand it takes a week to process my request

Purpose
(Check appropriate)

____ For other doctors involved in my care: Dr. _____
____ Transfer of care to Dr. (Name):_____
____ Disability evaluation
____ Insurance
____ Legal Matter
____ Employment-related issues
____ School
____ Personal
____ Other (please specify)
_____

INFORMATION TO BE RELEASED (PLEASE CHECK ALL THAT APPLY AND SPECIFY DATES):

__ Summary Letters_____
__ Clinic Visit notes_____
__ Photos/Fluorescein Angiography Reports_____
__ OCT (Ocular Coherence Tomography) Reports_____
__ Ultrasound Reports_____
__ Operative/Laser/Procedure Notes_____
__ Lab Reports_____
__ Visual Field Reports_____
__ Other (please specify)_____

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I understand that:

I may withdraw my authorization at any time by submitting a written request to Dr. Tang. Authorization may be withdrawn expect for the following:

-to the extent that action has been taken in reliance on this authorization.

-if the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.

I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment and payment will not be affected.

Information released on this authorization, if redisclosed by the recipient, is no longer protected by Retina Eye Care, P.C.

I understand that this authorization will automatically expire in 6 months unless otherwise specified.

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclose of the information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signatuare: _____ Date: _____
Print Name:_____
When patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required.

Signature of Legal Representative:_____ Date: _____
Print Name: _____ Relationship of representative to patient:_____

PLEASE MAKE YOUR CHECK OF $15 PAYABLE TO RETINA EYE CARE P.C. RETURN THIS FORM WITH PAYMENT TO:

RETINA EYE CARE P.C.
182 W. CENTRAL STREET, SUITE 102
NATICK, MA 01760

FOR INTERNAL USE ONLY

Medical Records Sent By:_____ Date: _____