LAKE EYE ASSOCIATES

A US EYE COMPANY

Person Number (office use only): _____

Authorization to Release Medical Records

Our office is dedicated to maintaining the privacy of your Protected Health Information (PHI). This includes such data as your name, address, phone number, date of birth, Social Security number, account information, medical record number, or any other unique identifying number. In conducting our business, we will maintain records regarding you and the treatment and services provided to you. We are required by law to maintain the confidentiality of health information that identifies you. ***Required field**

Patient Name* | Date of Birth*

Address* | City/State/Zip*

☐ **Release Records To** / ☐ **Request Records From**

Physician/Entity/Person | Facility

Address | City/State/Zip

Phone | Fax

Date of treatment for which records are needed*: _____

***Information/Documents to be released:**

☐ Chart Notes
☐ Office Notes
☐ Visual Fields
☐ OCT
☐ Corneal Topography
☐ A-Scans / IOL Calculations
☐ Fundus Photos
☐ Photographs
☐ Lab Reports
☐ Imaging Reports
☐ Entire Medical Record
☐ Other (Specify) _____

***Information will be used/disclosed for the following purpose(s):**

☐ Personal - Relocating
☐ Personal - Insurance Change
☐ Continuing Medical Care
☐ Insurance
☐ Attorney/Legal
☐ Social Service/Disability
☐ Worker's Compensation
☐ Other _____
_____

By signing this form, I authorize and request the release of confidential health information about me by releasing a copy of my medical records or a summary of my protected health information to the person(s) or entity listed above.

I understand that the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I understand that this authorization shall be valid for one (1) year unless otherwise states below or revoked through written notice to: **Privacy Officer, Lake Eye Associates, 5431 FL-44, Wildwood, FL 34785.** (Alternate date if not 1 year: _____)

PLEASE SEND REQUESTED MEDICAL RECORDS TO:

Lake Eye Associates Attn: Medical Records
5431 SR 44
Wildwood, FL 34785
Phone: (352) 632-2020 Fax: (352) 632-2038

Signature of Patient/Representative | Date

Printed Name of Patient/Representative* | Relationship to Patient*