children's
EYE CARE

PEDIATRIC OPHTHALMOLOGY + ADULT STRABISMUS

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RECORDS RELEASE

I AUTHORIZE AND REQUEST (*THE SENDER*):
(this is who you want to get records from)

DOCTOR'S NAME:_____

ADDRESS:_____

PHONE:_____ FAX: _____

TO SEND ALL OF MY RECORDS TO (*THE RECEIVER*):
(this is who you want the records to go to)

NAME: _____

ADDRESS:_____

PHONE:_____ FAX: _____

By my signature, I authorize that my protected health information (PHI) may be used or disclosed by the sender. I authorize my PHI to be forwarded to the receiver. I understand that the PHI, which is used or disclosed pursuant to this Authorization, may be subject to re-disclosure by the recipient and may lose the protection of confidentiality under the privacy rules. I understand that I have the right to inspect and copy the PHI that will be used or disclosed pursuant to this Authorization. I understand that the sender and receiver will not condition any aspect of my treatment, payment, enrollment in the health plan or eligibility for benefits on whether or not I sign this Authorization. I understand that I am under no obligation to sign this Authorization. I understand this authorization will expire 60 days after the date I signed it. I understand that this Authorization may be revoked in writing at any time. By my signing the Authorization, I acknowledge that I have read and understand this Authorization. Further, I give my authorization to the sender to use or disclose PHI in accordance to the terms of the Authorization.

PATIENT'S NAME (PRINTED): _____

PATIENT'S SOCIAL SECURITY #: _____ PATIENT'S DATE OF BIRTH:_____

PATIENT/PARENT/GUARDIAN'S SIGNATURE: _____ DATE:_____

PARENT/GUARDIAN'S PRINTED NAME (IF APPLICABLE):_____