MEDICAL RECORDS RELEASE FORM

PATIENT NAME:_____ DATE OF BIRTH:_____

Patient/Guardian Authorization

Overlake EyeCare may use, disclose or request the following information:

- ☐ All of my health information
- ☐ Other: _____

- ☐ You may disclose this health information to:
- ☐ You may request this health information from:

Name: _____

Address: _____

Phone: _____ Fax: _____

I want this information to be:

- ☐ Faxed
- ☐ Mailed ($24 charge for copies of your medical record up to 75 pages unless my copies are being sent to another physician or healthcare facility)

This authorization is valid until provided written or electronic notice of revocation is provided. I authorize the releasing individual or group listed above to release or obtain health information identifying me to the receiving individual or group including, if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services under the following terms and conditions. I understand I cannot revoke this authorization retroactively for information already released.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian)

Overlake EyeCare, P.S.
We're Focused On You

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