Medical Records Release Form

www.oceyeinstitute.com

Patient's Full Name: ______________________ **DOB*:** ______________

Address*: ______________________ **Phone Number*:** ______________

Release of Medical Records To:

Name: ______________ **Fax:** __________ **Phone Number:** ______________

Address: ____

Type of Information: ______________ **Reason for Disclosure:** ______________

Date of Service: ____

Release of Medical Records From:

Name: ______________ **Fax:** __________ **Phone Number:** ______________

Address: ____

Type of Information: ______________ **Reason for Disclosure:** ______________

Date of Service: ____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) when uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition or securing insurance coverage, and the insurer by law has the right to contest a claim or insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing, and without my expressed revocation, this consent will automatically expire 90 days from today's date. I understand that the information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards. A fax company or photocopy of this consent shall be as valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse, or psychological/psychiatric conditions. ☐ **I Do** ☐ **I Do Not**

***If this authorization is signed by an individual's personal representative, the representative's authority is based on (e.g., state law, court order, POA, etc...) ____

FEE SCHEDULE:

- States and federal laws specify a reasonable fee may be a charge to offset the cost associated with the reproduction of records. The fee is **$25.00** for clerical costs. No fee shall be a charge for reproducing and forwarding records directly to other physicians.
- I hereby authorized **Orange County Eye Institute**, or any of its employee or staff to use and/or disclose the protected health information as specified above.

Patient / Legal Guardian Signature*: ______________________

Patient Name*: ______________________

Date*: ______________________