Release of Information

Patient Name:______________________________________Date of Birth:__________________________
Address:________________________________________________________________________________
Phone Number:______________________________

I request that ________________________________ accept this request and release my records as stated below.

I request the release of healthcare records in the designated record set as checked below:

- o Exam/Office Notes
- o Special Testing
- o Prescription History (medication)
- o Eyewear prescription (glasses and contact lenses)
- o Medical Lab Results

From the following date range:_____________________________ to _____________________________.

Please release this information to: (circle one) Patient or Physician

If to a Physician:

Practice/Physician Name:___________________________________________________________

Address:__________________________________________________________________

Phone:_____________________________________

Fax:_______________________________________

The purpose of this release of information is:

- o Furthering Medical Care
- o Insurance (claim/eligibility/determination)
- o Personal Use
- o Other:____________________________________________

This release is in effect until:

- o One-time release
- o Other specified expiration (not to exceed one year)________________________________

Patient Signature:_________________________________________Date:__________________________

If person other than patient, please supply supporting documentation and complete the following.

Signature of Authorized person:____________________________________________________________
Relationship:______________________________________Date:_________________________________