EAGLE VISION & EYE CLINIC, PC

Doctors of Optometry
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REQUEST FOR RECORDS RELEASE

PATIENT NAME: _____ DATE OF BIRTH: _____

[ ] I do hereby give permission for:

Name: Dr. _____
Phone: _____
Fax: _____

to release a summary of my eye health records to Eagle Vision & Eye Clinic.

[ ] I do hereby give Eagle Vision & Eye Clinic permission to release a summary of my eye health records to:

Name: Dr. _____
Phone: _____
Fax: _____

[ ] I am requesting a summary of my own records. (Best option for most situations)
Please release to:
[ ] myself
[ ] other (Name) _____ Relationship: _____

[ ] I authorize: _____ Relationship: _____
to receive any medical information regarding me.

[ ] I would like to be able to receive documents and/or information via regular unsecured email and accept the risk involved.
(Per HIPAA regulations we are unable to send Protected Health Information (PHI ie: Records via unsecured or unencrypted email)

[ ] Please check this box if a summary is not sufficient and you request the entire record
(This may take up to 30 days, and require a large amount of paper)
Fees: Up to 10 pages no charge, 11-20 pages $10.00, more than 20 pages $20.00

Patient Signature: _____ Date: _____

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