The Eye Center Surgeons & Associates

401 Meridian Street, Suite 200 Huntsville, AL 35801 (256)705-3937

Authorization to Release Medical Records

I understand there is a fee of $10.00 for the first five pages or less of the medical record and $0.50 per page for all pages thereafter. There is NOT a fee to release records directly to another physician but authorization may still be required.

My signature below authorizes The Eye Center Surgeons and Associates, LLC, physicians and staff, to release or request my medical records.

☐ I wish to release my medical records **from** The Eye Center Surgeons and Associates, LLC **to**:

☐ I wish to release my medical records **to** The Eye Center Surgeons and Associates, LLC **from**:

Patient Name: ______________________________ **DOB:** ____________________

To Whom: ______________________________ **EMR #** (office use): ______________

Address: ____

City/State/Zip: ____

Phone Number: ____________________ Fax Number: ____________________

Please specify the purpose for the disclosure:

____

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____

Specific description of information to be disclosed (including dates):

____

____

Please specify the desired method for the release:

___ I will pick them up myself

___ I allow this person to pick up with proof of ID: ______________________

___ Mail to: ______________________________________

___ Fax to: (   ) ____________________ Attn: ______________________

***** We can only hard fax or electronically fax to healthcare providers*****

This authorization will expire ___________ (indicate date or an event relating to you personally or to the purpose of the authorization)

Are there limitations on the information to be released: ___ Yes ___ No

Please list:

____

I understand that I may revoke this authorization in writing at any time (except with respect to information disclosed pursuant to this authorization prior to such revocation) and that unless a different date is specified, this authorization will automatically expire 12 months after the date of execution by me. I acknowledge that, once the information is used or disclosed, it may be re-disclosed by the recipient and no longer protected from disclosure by Federal or State law. A copy of this authorization may be utilized with the same effectiveness as an original. I acknowledge that The Eye Center may not condition my treatment on my execution of this authorization.

I acknowledge that The Eye Center ___ will ___ will not receive payment or other remuneration from a third party in exchange for using or disclosing my protected health information.

My signature below indicates that I understand the authorization to obtain or release my private health information.

Print Name: ______________________ Signature: ______________________ Date: __________

Office Use Only: Date Records Released: ______________ DL# ______________________

Amount charged for records: $ __________ Employee Initials: __________

Form of payment: ___ Cash ___ Credit Card ___ Personal Check

REVISED 06/06/17 AGH