

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 search/retrieval fee of \$5.00. The first twenty-five pages or less of the record will be \$1.00 per page. Pages over twenty-five \$0.50 per page. 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 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:

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 will not condition my treatment, payment, enrollment, eligibility for benefits on whether I sign this authorization, except as otherwise permitted by law.

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

EYE CENTER SURGEONS & ASSOCIATES

Medical Records Fees & Release Process

Requesting Medical Records

To obtain copies of medical records, patients or authorized representatives must complete and sign a Medical Records Request Form. Requests may be submitted in person, by mail, fax, or secure email.

Records may only be released to:

- The patient
- A parent or legal guardian (when applicable)
- An individual authorized by the patient
- An attorney with a valid authorization
- Insurance companies or other entities authorized by the patient
- Healthcare providers involved in the patient's treatment

Valid identification may be required before records are released.

Processing Time

Medical record requests are typically processed within **7–14 business days** from receipt of the completed authorization and any required payment.

Fee Schedule

In accordance with Alabama law, the following fees may apply:

<u>Description</u>	<u>Fee</u>
Search/Retrieval Fee	\$5.00
First 25 pages	\$1.00 per page
Pages Over 25	\$0.50 per page
Postage	Actual Cost

No Charge Requests

Fees are generally waived for:

- Records sent directly to another physician or healthcare provider for continuity of care.
- Certain requests required by law.