EYEDEAL EYECARE
OF MILFORD

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:_____ Date of Birth:_____

Patient Phone:_____

❑ Receive health information from: - OR - ❑ Release health information to:

Name of patient, provider, or facility:_____

Street address, City, State, Zip:_____

Phone Number:_____ Fax Number:_____

Please include all the specified documents:

☒ Clinic Notes	☒ Visual Fields	❑ Fundus Photos	❑ Pathology Reports
❑ Surgical Notes	☒ OCT	❑ Lab Reports	❑ Radiology Reports

Please <u>MAIL</u> all medical records for continuity of care to:
EyeDeal Eyecare: 189 Elm Street, Ste 6, Milford, NH 03055.

I hereby authorize Eyedeal Eyecare of Milford to obtain the specified information as stated in this authorization. I understand that the information in my health record may include information relating to sexually transmitted diseases, HIV/AIDS, mental health and drug or alcohol abuse. I hereby release Eyedeal Eyecare and its employees from any and all liability that may arise from the release of information as I have directed. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Without my express revocation, the authorization will automatically expire one year from the date of signature. When your health information is disclosed under this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

- I HAVE READ AND UNDERSTAND THIS FORM. THERE WILL BE A $20.00 FEE FOR MEDICAL RECORDS RELEASED DIRECTLY TO PATIENTS.

Patient Signature:_____ Date:_____

If you are signing as a legal representative of the patient, please indicate your relationship.