

Authorization for Release of Medical Information

TO: _____

Address: _____

City: _____ State: _____ Zip: _____

I hereby authorize the release of my eye examination records or copies of such and request that they be transferred to:

COMPLETE EYE CARE
1200 SPRUCE STREET
BELMONT, NC 28012

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. This signed authorization for release of medical information will be valid for 180 days, after which another authorization must be signed in order to release the information requested.

I understand that the recipient of this Health Information may not use or disclose the Health Information unless another authorization is obtained from me or unless such use or disclose is specifically required or permitted by law. I understand that if the person or organization I authorize to receive my protected Health Information is not a health plan or health care provider, my Health Information may no longer be protected by federal privacy regulations once it is disclosed.

Name: _____

Date of birth: _____

From: _____ to _____

Date of records

Patient's Signature: _____