COMMUNITY EYE CARE SPECIALISTS

COMMUNITY SURGERYANDLASER CENTER

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Authorization for Release of Protected Health Information

I hereby give my permission to release medical information as indicated below:

_____ _____
Patient Name Date of Birth

Records are requested for the purpose of:

☐ Second Opinion ☐ Transfer of Care
☐ Insurance Purposes ☐ Continuing Care
☐ Relocating – (please provide address) _____

☐Other: _____

Indicate specific records to be released:

☐ Office Visits / Testing Dates of Service: _____
☐ Surgery Dates of Service: _____
☐ All Records Dates of Service: _____
☐ Lab Work ☐ Pathology ☐ Imaging
☐ Other: _____

Release Records to: **Release Records from:**

Fax #: _____ _____
E-mail: _____ _____
Phone: _____ _____

I understand that this authorization is effective for a period of one year from the date of signature, unless otherwise specified. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity / person I authorized above to release this information.

_____ _____
Patient Signature Date

_____ _____
Parent (for patients under the age of 18) / Guardian Date

_____
Relationship to Patient