Jeffries Eye Clinic, P.A.

Rev 01/ 2005

Medical Records Release Form

____ ______________________ _______________________
Patient Name: Last, First, Middle **Date of Birth** **Contact Phone #**

I Hereby Authorize:
(Name & Address of releasing facility)

To Release Information to:
(Individual name, facility/organization & address)

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PURPOSE OF DISCLOSURE:

( ) **Continuing Care** ( ) **Legal** ( ) **For Personal Use**
( ) **School** ( ) **Worker's Compensation**
( ) **Other (Specify):**____

INFORMATION TO BE RELEASED: (Please check all that apply)

( ) **Complete Medical Record** ( ) **Diagnostic test reports** ( ) **Exams**
( ) **Procedure Reports** ( ) **Other:** ____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- **I understand that the information in my medical records may include information relating to communicable disease(s), Acquired Immunodeficiency Syndrome ("AIDS"), or Human Immunodeficiency Virus ("HIV"), behavioral or mental health, alcohol/drug abuse or any such related information.**
- **I understand the expiration date of this authorization is one (1) year.**
- **I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it well be effective on the date notified except to the extent action had already been taken.**
- **I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.**
- **I understand by authorizing this use disclosure of information, there will be no conditions placed on my health care or payment for my health care.**

____ ________________________________ _____________________
Signature of patient, Parent, or Legal Representative **Relationship** **Date**

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