Eyesight
Uncompromising Care

Authorization for Release of Medical Records

Patient Information

Name: _____ DOB: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____ Email: _____

☐ Check here if records are to be mailed to **you** via the address above **** 2+ Visits - $15 flat rate ****

I hereby authorize *Eyesight* to:

☐ Disclose my medical record information to: **OR** ☐ Obtain medical information from:

Provider/Practice/Facility: _____

City, State, Zip Code: _____

Phone: _____ Fax: _____

Records being requested: _____

If my medical records contain information regarding substance abuse, mental health conditions, and STD's/HIV/AIDS, **I DO ____ I DO NOT ____ Authorize the release of this information.**

I Understand that:

- Eyesight will treat me even if I decline to sign this authorization.

- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.

- Information disclosed under this authorization might be re-disclosed by the recipient and this re-discloser may no longer be protected by federal or state laws.

- I can revoke this authorization at any time by submitting a request in writing to Eyesight. This will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

- This authorization expires one year from the date of signature or on: _____

_____ _____ _____

Signature of patient or legal representative/Guardian - **Relationship to patient if applicable** - **Date**

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■ MedicalRecords@EyesightNH.com ■