RECORDS RELEASE AUTHORIZATION

Date Requested:_______________

Please fill out completely and allow 7-10 business days to process.

To Be Released From:

THE EYE GALLERY, 609 E MCMURRAY ROAD, MCMURRAY PA 15317

By checking below, I specifically authorize use and / or disclosure of the following Health Information

- ○ Entire Medical Records
- ○ Glasses Rx Only
- ○ Contact Lens RX Only
- ○ Contact / Glasses RX Only

To Be Sent To: (Please Print) ○ Fax ○ Mail ○ Pick Up

Name:____

Phone:_______________________ Fax:_______________________

Address:____

City/State/Zip Code:_______________________________________

I hereby authorize, **THE EYE GALLERY** to release the protected health information (Medical Record) pertaining to my illness/treatment at your facility, including any and all records.

This authorization is valid for one year from date signed

Patient Information: Patient Name:_______________________ Date of Birth________

Address:_______________________City/State/Zip_______________________

Phone Number: _______________Patients Signature_______________________

Authority of Legal Representative (If not self, select one below)

○ Parent of Minor ○ Court Aoointed Guardian ○ Other

Protected Health Information is personal and sensitive information related to an individual's health care. It is being transmitted to you by facsimile or email after appropriate authorization from the patient or under circumstances that do not require patient authorization. You as the recipient are obligated to maintain this information in a safe, secure and confidential manner. Re-disclosure of this information without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure of failure to maintain confidentiality could subject you to penalties described in federal and state law. If you have received this message in error, please notify the sender to arrange for return or destruction of these documents.