MEDICAL RECORDS RELEASE FORM

I, (Please Print) **Patient Name** ______________________ **Date of Birth:** ____________

authorize Silverstein Eye Centers to release a copy of my medical record to::

Please Provide Records Via:

○ Mailing address: ______________________

○ FAX # (   )   - ____________

○ Pick up in office

My physician at Silverstein Eye Centers is/was: ______________________

Reason for Request: ○ moving ○ changed insurance ○ transferring care for other reason

○ release info to specialist ○ other ______________________

I specifically authorize the release of the following:

○ Pertinent Record
(Includes the previous 3 years of office notes, lab work, and ALL other pertinent tests)

○ Entire Chart
(Please be aware there may be a charge for this, depending on the size of the chart.
The entire record will remain on file indefinitely in our electronic record if there is ever a need to access it. Most physicians will not require the entire chart)

Patient Comments/Notes

I expressly and voluntarily authorize disclosure of the above medical record information.
I further understand that I am not giving permission for any disclosure other than described above.
I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization.

This release is effective for 90 days from the date signed, unless otherwise specified as follows: ______________________. I understand that the parties in receipt of these records may not further disclose the medical information unless another authorization is obtained for me, or unless such disclosure is specifically required or permitted by law.

Charges: I further understand that Silverstein Eye Centers, in accordance with State Law, may have a print fee, which will be disclosed at the time the request is processed. I agree to pay these charges plus any postage.

PATIENT SIGNATURE: ______________________ DATE: ____________