SILVERSTEIN EYE CENTERS P.C.

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MEDICAL RECORDS RELEASE FORM

I, (Please Print) **Patient Name** _____ **Date of Birth** _____
authorize the release of a copy of my medical records

FROM (Physician and Healthcare Facility) _____

TO (Physician and Healthcare Facility) _____

Please Provide Records Via:

- ◯ Mailing address: _____
- ◯ FAX # ( ) -
- ◯ Pick up in office

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 – all records, except Substance Abuse, Mental Health, HIV Diagnosis/Treatment.
(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 in accordance with State Law, I 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: _____