Clear Vision Ophthalmology

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Medical Record Release Authorization

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records to the physician/person/facility/ listed below.

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

The information you may release subject to this signed release is as follows:

- ☐ Complete Medical Record
- ☐ Care Plan
- ☐ History and Physicals
- ☐ Lab Reports
- ☐ Treatment Records
- ☐ Medication Records
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ Other (please specify)

My signature below authorizes you to release my protected health information to the following physician/person/facility and/or those directly associated with my medical care:

Facility/Provider: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

E-Mail Address: _____

Signature: _____ Date: _____