LASIK MD VISION

## AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

*Please email the completed form to **medicalrecords@lasikmd.com***

### Patient personal information

Name: _____ Date of Birth: _____

Address: _____

Telephone Home: (_____) _____

Work: (_____) _____

I authorize the LASIK MD to disclose my medical record to:

Name: _____

Address: _____

Email:_____

Reason for request: _____

Information to be Disclosed:

a) Dates of Service:_____

b) Type of Records (check or specify)

- ☐ All medical records
- ☐ Progress notes
- ☐ Lab/test results
- ☐ Imaging reports
- ☐ Other: _____

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it.

**This authorization will automatically expire in 60 days OR fill in the Date or the Event that you want it to expire (but not both).**

**Date: _____ Event: _____**

_____ _____

Patient or Personal Representative's Signature Print Name

Date: _____

If executed by a personal representative, relationship to patient:_____ (e.g. "as parent" or "as legal guardian").

**For internal use only:**

Authorized Representative approval for release (Signature): _____

Authorized Representative (Printed Name): _____

Authorized Representative approval date: _____

Medical Record sent by:

- ☐ Fax
- ☐ Registered Mail
- ☐ Handed to patient in person
- ☐ Other (please specify) _____

Date Medical Record sent: _____