Concord Eye Center

248 Pleasant St., Suite 1600 | 2 Pillsbury St, Suite 100 | Concord, NH 03301 | (603) 224-2020 Fax (603) 228-0248

Authorization for Release of Medical Records

Please fill one form per party.

Patient Name: _____ DOB: _____ Chart # *(office use only):* _____

I authorize Concord Eye Center to (*please choose only one*):

☐ Send/Disclose information **TO**: ☐ Receive information **FROM**:

Name: _____ Phone#:_____

Address: _____ Fax#: _____

Information to be released: (please check or initial)

_____ All records regarding my care at this facility

_____ Records relating to treatment dates from: _____ to: _____

If my medical records contain information regarding drug/alcohol abuse; physical/sexual abuse; Sexually transmitted diseases including HIV/AIDS; psychiatric/psychological conditions,

I DO _____ I DO NOT _____ authorize the release of that information.

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained insurance coverage and the insurer has the legal right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must send written notification to Concord Eye Center.

We strive for a prompt turnaround time, but in some circumstances, it may take longer. If you require records in a certain time frame please, indicate so by noting when you need them by here: _____ and we will do our best to meet such request.

A fax copy or photocopy of this consent shall be valid as the original.

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproductions of records; I may be subject to a fee of $15.00 for the first 30 pages and $.50 for each additional page. No fee shall be charged for reproducing and forwarding records directly to other physicians.

_____ _____

Patient/legal guardian signature Date

_____

Printed name and relationship to patient if not patient signing

*If there is a Power of Attorney, or Appointed Guardianship, we do require those documents on file at Concord Eye Center prior to any records being released.

This authorization is valid for one year from date of signature, or on: _____

For office use only:

Authorization _____ Date Sent: _____ By: _____