Asheville Eye Associates

Authorization for Release of Medical Records

(Protected Health Information)

Date Received: _____ Date Released: _____

Please allow 72 hours after date of receipt for request to be processed

_____ Authorizes the release of records as indicated below:
Patient/Name of Health Care Provider / Plan/Other **Date of Birth**

From:	**To:**
_____	_____
Patient/Name of Health Care Provider/Plan/Other	**Patient/Name of Health Care Provider/Plan/Other**
_____	_____
Address **Fax #**	**Address** **Fax #**
_____	_____
City **State** **Zip**	**City** **State** **Zip**

My authorization applies to the following (check all that apply):

□ All medical records (include diagnostic tests)
□ Contact Lens, including original K's
□ Lab/Imaging Results
□ Only information on the following dates/conditions: _____
If left blank, only information from the past two years will be disclosed
□ Other (specify): _____

My protected health information is requested to be released for the following purposes (check as many as apply):

□ Personal records □ Continued medical care □ Insurance claim
□ Leaving Asheville Eye Associates – to help us improve the quality of our patient care, please explain your reason for leaving: _____
□ Other (specify): _____

I understand if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations that the information may be re-disclosed and would no longer be protected, and Asheville Eye Associates cannot be held liable.

I understand that there will be a processing fee of $10 for copies of my medical records due at the time of my request.

I understand that I have a right to inspect and receive copies of my own protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I certify that I have read and understand the medical record release process and authorize the release of my medical records.

_____ _____ Signature
Date

_____ _____
Name Date of Birth

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient (if applicable)

_____ _____
Witness Date

Office Use Only:

Photo ID Obtained: _____ # of pages released: _____

Record released by: _____ Date: _____ Time: _____