MID OHIO EYE
Physicians & Surgeons

The difference is clear!

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Medical Records Release Form

Patient Name: _____ **Date of Birth:** _____
Last 4 of SS#: _____ **Phone Number:** _____
Street Address: _____
City: _____ **State:** _____ **Zip:** _____

I authorize Mid Ohio Eye to:

___ Release medical information to:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

___ Receive information from:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

Purpose of disclosure:

_____

Date(s) of Service and specific information to be disclosed:

___ Exam summary ___ Test Reports ___ Prescription(s) ___ Discharge instructions
___ Other: _____

This authorization will expire: ___ 60 days from date of signature ___ Other (specify) _____

Statement of Understanding:

- I may revoke this authorization at any time in writing, although such a revocation will not apply to information already used or disclosed in response to this authorization. Please refer to the Mid Ohio Eye Notice of Privacy Practices for additional information regarding revocation and disclosure of PHI;
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements;
- I understand and acknowledge that this authorization extends to use and /or disclosure from my medical record, which may include treatment for physical and mental illness, alcohol and/or drug abuse, and /or AIDS, and/or may include results of an HIV test or the fact that an HIV test was performed;
- Mid Ohio Eye will not condition the provision of treatment, payment, enrollment, or eligibility for benefits based on the execution of this authorization;

_____ _____
Signature of Patient/Authorized Representative Date

_____ _____
Printed Name Relationship, if not the patient