Authorization to Release Copies of a Medical Record from Complete Eye Care

(Patient requests information to be sent from Complete Eye Care)

This authorization is voluntary. I understand that Complete Eye Care will not base treatment on my signing this document. Unless otherwise revoked, this authorization will expire 6 months from the date it is signed. I understand I can revoke this authorization in writing up until the time it is processed. Once information has been disclosed, Complete Eye Care can no longer protect it from further disclosure. The average turnaround time for processing this request is 4-5 business days.

Patient Information:

First Name: ______________________________ Middle Initial: ______ Last Name: _______________________________

Date of Birth: ____________________________ Phone #: ____

Street: ____ City: ______________________ State: ____ Zip: _____

Records Request:

I request that my medical records be released from Complete Eye Care/John A. Waters, M.D., 5055 W. Bristol Rd, Flint, MI 48507, PH 810-732-2272 to:

_____ **MYSELF.** I request that Complete Eye Care release my protected health information (medical records) to me in the one of the following methods:
___ FAX (please provide fax number) ____________________________
___ mail to the above address
___I will pick up from CEC

_____ **OTHER.** I am the patient, or the legally authorized representative of the patient listed above, and request that Complete Eye Care release my protected health information (medical records) to:

Contact Name: _________________________________ Organization Name: _______________________________________

Street: ____ City: ______________________ State: ____ Zip: _____

Phone #: ____ Fax #: ____

Select Delivery Method: _____ U.S. Mail _____ Fax _____ Secure Direct Email (if available)

Purpose of Release:
_____ Continuation of Care
_____ Transfer of Care and Discharge
_____ Other: ____________________________

Information to be Released:
____ All Records
____ Date Range: _____________________
____ Other: __________________________

I acknowledge that I have read the information on this release form and understand the terms and conditions of this authorization.

____ ____
Signature of Patient or Legally Authorized Representative Date

____ ____
Print Name of Legally Authorized Representative Relationship to Patient