General Medical Records Release and Authorization for Use of Disclosure of Protected Health Information

Please Complete the Following Information:

Patient Name: ____

Patient Date of Birth: _____/_____/_____

I authorize the following Provider/Entity:

☐ Cataract and Eye Disease Specialists
9 Point West Blvd.
St. Charles, MO. 63301
636-441-7900
636-441-1980

☐ Name:___________________________
Address: ________________________
____
Phone: __________________________
Fax: ____________________________

To disclose/release the following information:

☐ All Records

☐ Laboratory/Pathology Records

☐ Radiology Records

☐ Billing Records

☐ Other____

To send records listed above to:

☐ Cataract and Eye Disease Specialists
9 Point West Blvd.
St. Charles, MO. 63301
636-441-7900
636-441-1980

☐ Name:___________________________
Address: ________________________
____
Phone: __________________________
Fax: ____________________________

This authorization shall not be valid for greater than one year from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

________________________________	________________________________
Signature of Patient (or patient representative)	Date
________________________________	________________________________
Printed name of patient (or representative)	Relationship to patient