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:
___ my patient portal
___ 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