Vision Source **YANKEE** EYE CLINIC **ROSEMOUNT** EYE CLINIC **CANNON** EYE CLINIC

REQUEST FOR RELEASE OF MEDICAL RECORDS

SECTION 1 **I hereby request the release of the medical records of:**

First Name:______________________Middle Name:______________________Last Name: ______________________

Patient DOB:___/___/_____Previous name(s): ____

Home address:____City:_____________________________

State:_________________Zip code:___________Daytime phone: ___________ E-mail address (optional):___________

_________________Medical Record/patient ID number (optional): _________

SECTION 2 **To be retrieved from the clinic below:**

Physician name: ________________________________

Clinic:____

Address:____

Phone:____

Fax: ____

Information needed by: / / (optional)

SECTION 3 **And delivered to the clinic/person below:**

Physician name: ________________________________

Clinic:____

And/or person: First name: _______________________

Last name: _____________________________________

Address:____

Phone:____

Fax: ____

SECTION 4 **Information to be released** (IMPORTANT: indicate only the information that you are authorizing to be released)

Specific dates/years of treatment: ____

☐ All health information

OR to only release specific portions of your health information, indicate the categories to be released:

☐ History/Physical ☐ Mental Health ☐ Immunizations
☐ Laboratory Report ☐ Care Plan ☐ HIV/AIDS testing
☐ Emergency Room Report ☐ Billing records ☐ Radiology Report
☐ Surgical Report ☐ Discharge Summary ☐ Radiology Image(s)
☐ Medications ☐ Progress Notes ☐ Photos/video/digital/other images
☐ Other information or instructions: ____

The following information requires special consent by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:

☐ Chemical dependency program ☐ Psychotherapy notes

SECTION 5 **Reason(s) for releasing information**

☐ Patient's request
☐ Review patient's current care
☐ Treatment/continued care
☐ Payment
☐ Insurance application
☐ Legal
☐ Appeal denial of Social Security Disability income or benefits
☐ Marketing purposes (payment or compensation involved? Circle: NO YES, amount: _________________
☐ Other (please explain): _______________________

SECTION 6 **Health information includes written and oral information.** By indicating any of the categories in section 4, you are giving permission for written information to be released and for a person in section 2 to talk to a person in section 3 about your health information. If you do not want to give your permission for a person in section 2 to talk to a person in section 3 about your health information, initial or check here: _______

SECTION 7 **I understand that** by signing this form, I am requesting that the health information specified in Section 4 be sent to the third party named in Section 3 above. I may stop this consent at any time by writing to the organization(s), facility(ies) and/or professional(s) named in section 2. If the organization, facility or professional named in section 2 has already released health information based on my consent, my request to stop will not work for that health information. I understand that when the health information specified in Section 4 is sent to the third party named in Section 3 above, the information could be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that if the organization named in section 3 is a health care provider they will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the consent form. If I choose not to sign this form and the organization named in Section 3 is an insurance company, my failure to sign will not impact my treatment; I may not be able to get new or different insurance; and/or I may not be able to get insurance payment for my care. I understand the party listed in section 2 legally has **30 days to produce document(s)** requested in section 4.

This consent will end one year from the date the form is signed unless I indicate an earlier date or event here: Date:___/___/_____

or specific event: ____

SECTION 8 Patient's signature:____Date:___/___/_____

OR legally authorized representative's signature_____________________________________Date:___/___/_____

Printed Name:___________________________________Relationship to patient: ___________________________

*Please note we will require a **copy of your photo ID** along with this completed form.*

Photo ID copied by (staff signature):