EYE CONSULTANTS

8141 WEST CENTER RD
OMAHA, NE 68124
PH-402-391-1100
FAX-402-391-1233

RELEASE OF MEDICAL RECORDS

Patient name_____DOB_____

Address_____
_____

Phone #_____

I hearby authorize and request release of my medical records:

FROM:_____
_____
_____
TO:_____
_____
_____

Purpose of release: Medical care Transferring care Personal Records Attorney

Information to be disclosed:_____

From(date):_____To(date)_____

This statement of consent can be revoked at any time before disclosure of the information, and expires on _____(expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed.

I understand that I may revoke this authorization at any time by notifying the providing organization in writing. If I revoke the authorization, it will not have any effect on actions taken prior to receipt of the revocation.

I understand that the individual/institute that receives the information described above may not be covered by federal privacy regulations, and that the information may be redisclosed publicly and no longer be protected by those regulations

Patient Signature_____ Date_____

Signature of parent, guardian,
or authorized representative _____ Date_____

Witness:_____