Permission for Release of Medical Records

Patient Name:_____
Date of Birth:_____

To/ From (circle appropriate)
Jamesburg Family Eyecare
Practitioner: Magdalena Spiewak O.D.
Phone: (732) 656-1515
Fax: (732) 656-1514

To/ From (circle appropriate)
Name of Provider:_____
Clinic Name:_____
Address:_____
City, State, Zip:_____
Phone:_____
Fax:_____

This information may include:
□·ALL health care information whether oral or recorded in any form or medium, that identifies the patient, or can readily be associated with the patient and relates to the patient's care. This will include all health care information in our possession whether generated by Jamesburg Family Eyecare or any other source.
Health care information associated with drug or alcohol use, mental or psychiatric care, HIV/AIDS status or other sexually transmitted diseases will be included. I understand that my consent is required to release information in relation to drug or alcohol abuse, mental illness, psychiatric treatment, AIDS and HIV status and sexually transmitted diseases.
□·ONLY the following:
_____My glasses and/or contact lens prescription
_____Copy of last eye exam
_____Copy of last visual field exam

I understand that I have the following rights:
• I do not have to sign this authorization to receive treatment and care at Jamesburg Family Eyecare.
• I am able to revoke this authorization at any time by filling out a Revocation Form or writing to our practice requesting the revocation of this authorization.
I understand that once health care information is disclosed to another party, Jamesburg Family Eyecare cannot protect the privacy of the released information. This authorization is effective 90-days from the date of the authorization (date specified below)
□·I give my permission to FAX this information. I am aware that the information that I am requesting to be transferred may contain protected health information. I also understand that Jamesburg Family Eyecare will not be liable in a situation where any information is transmitted through FAX to an erroneous third-party. (Initial)____

_____ _____
Patient or Parent/Legal Guardian Signature **Printed Name**

_____ _____
Date **Relationship to Patient**