REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME_____DOB_____PHONE_____
PATIENT
ADDRESS_____CITY_____STATE____ZIP_____
I HEREBY AUTHORIZE: **LEWYCKYJ TAGLIA FELTON EYE CLINIC, 2101 BURLINGTON BEACH RD VALPARAISO, IN 46383 PHONE: 219-462-0309 FAX: 219-464-4291**

TO RELEASE TO: NAME_____PHONE_____

ADDRESS_____CITY_____STATE___ZIP_____
FAX_____

A. Only those medical records and correspondence minimally necessary INCLUDING all records regarding mental health/drug, alcohol treatment and/or HIV, AIDS, or communicable disease information.
OR
B. The following specific portions or dates of service of my medical record

1. History and Physical
2. Discharge Summary
3. Operative Report
4. Outpatient therapy
5. Emergency room
6. Laboratory tests
7. Other test results
Kinds:_____
_____

OTHER:_____
FROM DATE_____TO DATE_____
FOR THE PURPOSE OF a) Self b) Attorney c) Other
d) Continued Care e) Insurance

I understand that the information in my health record may include information relating to mental health/drug, alcohol treatment and/or HIV, AIDS, or communicable disease.
It is understood that this authorization is subject to written revocation by me at anytime except for information that has already been released in response to this authorization. This authorization shall remain valid until revoked and will expire in 60 days or upon the following event or condition:_____.
I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 42 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
PATIENT SIGNATURE SIGNATURE OF OTHER AUTHORIZED PERSON**

_____ _____
DATE RELATIONSHIP OF AUTHORIZED PERSON**

**The signature of a parent (including a non-custodial parent provided there are no court-ordered restrictions) or legal guardian is required for any unemancipated patient under the age of 18. A parent, guardian, or custodian may sign for an incompetent patient. The personal representative of the estate may sign for a deceased patient; if no personal representative, the spouse may sign for a deceased patient; if no spouse or personal representative, an adult child may sign for a deceased patient.