Kalamazoo Ophthalmology, P.C.
Medical Records Release

3412 W. Centre Ave, Portage, MI 49024
Phone # (269) 329-5860 Fax # (269) 329-5865

(Name of Patient) _____ (Birthdate) _____

(Street Address) _____ (City, State, Zip Code) _____

Authorizes:

(Name of Physician or Health Care Facility) _____

(Street Address) _____

(City, State, Zip Code) _____

Release of Records to:

(Name of Physician or Health Care Facility) _____

(Street Address) _____

(City, State, Zip Code) _____

Information to be released:

[ ] 3 Most recent visits with applicable testing
[ ] Photographs
[ ] Lab Reports
[ ] Visual Fields / OCT's
[ ] Other (specify) _____

List other facilities' records to be included when releasing for the purpose of continuing medical care:

_____

For the following dates: _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

[ ] Mental Health
[ ] Drug Abuse
[ ] AIDS-related disease diagnosis
[ ] AIDS test results
[ ] Alcoholism
[ ] Developmental Disabilities
[ ] Other (specify) _____

Purpose or need for disclosure: (Check all applicable)

[ ] Further medical care
[ ] Application for Insurance
[ ] Disability Determination
[ ] Vocational rehabilitational evaluation
[ ] Personal
[ ] Legal Investigation
[ ] Other (Specify) _____

I understand that this authorization is valid for one (1) year unless otherwise stated below or revoked through written notice to the Privacy Officer of the Practice. _____ (Alternate date if not one year)

Please note, HIPAA does not allow this organization to condition treatment, payment, enrollment, or eligibilty for benefits upon receiving this authorization. The above mentioned protected health information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form you authorize the Practice to use and disclose protected health information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior authorization.

Signature of Patient _____ **Date:** _____
(If signed by person other than patient, state relationship and authorization to do so)

(Authorized Signature) _____ (Relationship) _____

Patient is: [ ] Minor [ ] Incompetent [ ] Disabled [ ] Deceased

Legal Authority: [ ] Legal [ ] Legal Guardian [ ] Next of kin of deceased