Authorization for Release of Medical Information

Patient Name:_____ Account #:_____

SSN:_____ DOB:_____

Requester:_____

Requester's Contact Number:_____

Date of Request:_____

Date(s) of Service to be Released:_____

to_____

Recipient of Records:_____

Recipient's Contact Number:_____

Records to be Released via (check all that apply):

☐ Fax: (#)_____

☐ Pickup: (#)_____

☐ Mail: (address)_____

_____

_____

Availability and Fees

Please note that most of your records will be available to you through the online portal free of charge.

- **Large Volume Medical Records Fee:** If the quantity of records requested is in excess of 100 pages or 5 years of records, you may be subject to a $25.00 processing fee.

- **Digital Records Fee:** If you request your records be issued to you digitally, there is a $5.00 fee to purchase a disc or USB flash drive for this purpose. Please note that you may not supply your own disc or USB flash drive. This is in compliance with HIPAA and Hi-Tech laws and policies to prevent the spread of computer viruses and/or corrupted files. Consequently, your purchased disc or USB drive will be unused and unopened prior to use for this purpose. Once issued, it cannot be returned to our office for a second use regardless of the time frame. If you would like to verify the contents of the disc or drive prior to payment, please ask to have a staff member lend you one of our own available tablets or laptops to review the contents.

Revocation

This authorization expires one (1) year from the date this authorization is signed or when this authorization is revoked, whichever happens first. You have the right to revoke your authorization before expiration by issuing a signed and dated letter of revocation to Mountain View Eye Center. Any information already released before the date of the revocation is covered under this authorization.

Acknowledgments

I, the undersigned, understand that I am authorizing the release of Patient information for the Dates of Service to the Recipient, as named above respectively. I acknowledge that after the information is released, Mountain View Eye Center is no longer responsible for the confidentiality of the information, regardless of the Recipient's requirement to comply with HIPAA laws and regulations. I understand that this authorization does not cover the release of any psychotherapy notes, and that release of any psychotherapy notes requires a separate, specified authorization that cannot be combined with any other authorization. I further understand that I have the right to treatment, payment, enrollment, or eligibility of benefits whether or not I sign this authorization, unless solely for the purpose of creating protected health information.

_____ _____

Signature of Patient, Guardian, or Legal Representative Date