Authorization for Release of Medical Information

Patient Name:______________________________ Account #:______________________________

SSN:______________________________ DOB:______________________________

Entity Requesting Records:____________________

Requester's Contact Number:____________________

Date of Request:____________________

Date(s) of Service to be Released:______________

to______________

Recipient of Records: Mountain View Eye Center

Recipient's Contact Number: 907-328-2920

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

- ☐ Fax:907-456-2914 (please mail images or >20 pages)
- ☐ Mail: (address) 2555 Phillips Field Rd
Fairbanks, AK 99709

Entity Releasing Records:____________________

Releaser's Contact Number:____________________

Relationship to Patient:____________________

Information to be Released (check all that apply):

- ☐ Progress Notes
- ☐ Procedure Notes
- ☐ Imaging Reports
- ☐ Lab Reports
- ☐ X-Ray Films
- ☐ Billing Records

Fees

Please call the Entity Requesting Records to discuss any fees that may be charged for the release of this information prior to releasing records. Fees to be charged to Mountain View Eye Center will not be paid unless prior approval from Mountain View Eye Center is obtained.

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 the above Patient information for the Dates of Service above to Mountain View Eye Center. I acknowledge that after the information is released, the Entity Releasing Records is no longer responsible for the confidentiality of the information. 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