Authorization for Release of Medical Information

Patient Name:_____ Account #:_____

SSN:_____ DOB:_____

I hereby authorize Mountain View Eye Center to (PLEASE INITIAL):

_____ Release Records To: _____ Obtain Records From:

Person/Agency:_____

Address:_____

City, State, Zip:_____

Phone/ Fax:_____

Information to be Released (check all that apply):

- ☐ Entire medical record (chart notes only)
- ☐ Appointment note, dates:_____
- ☐ Imaging results, dates: _____
- ☐ Other, description, dates: _____

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 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:** There is a $5.00 fee to purchase a disc or USB flash drive for an electronic copy.

Expiration, Revocation, Re-Disclosure, Acknowledgements:

This authorization expires one (1) year from the date of signature. I understand I have the right to revoke this 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 revocation is covered under this authorization. When releasing your medical information be aware that the information may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations.

I understand that my medical records may include sensitive health information including but not limited to the diagnosis and treatment related to drug and/or alcohol abuse, AIDS/HIV status and or STD's. I understand and agree that the information, if any, pertaining to any such diagnosis/treatment described above may be released. I understand that this authorization does not cover the release of psychotherapy notes, and that release of any such notes requires a separate, specified authorization that cannot be combined with any other authorization.

I understand that Mountain View Eye Center will not condition my treatment, payment, enrollment in a health plan (if applicable) or eligibility for benefits on whether I provide this authorization. I understand that I may request a copy of this signed authorization.

_____ _____

Signature of Patient, Guardian, or Legal Representative Date

_____

Relationship to Patient

2555 Phillips Field Road, Suite 101, Fairbanks, AK 99709
Phone: (907) 238-2920 Fax: (907) 456-2914 fax