LODESTAR
FAMILY EYE CARE, PC

Records Release

1) **PATIENT INFORMATION**:

_____ _____
Name (First and Last) Date of Birth

_____
Previous Name

2) **AUTHORIZES**:

_____
Name of Health Care Provider / Plan / Other

_____
Address City State Zip

(_____)_____
Fax

3) **TO DISCLOSE TO**:

Send to: _____
Name of Health Care Provider / Plan / Other

(_____)_____
Fax

4) **INFORMATION TO BE DISCLOSED**:

_____All medical records **OR** From _____ to _____
*If left blank, only information from the past two (2) years will be disclosed.

5) **PURPOSE** (Check all that apply - copy fees may apply)

_____Further Medical Care _____Legal Investigation /Action
_____Insurance Eligibility/Benefits _____Personal (at my request)
_____Other: _____

6) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION**: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

7) **SIGNATURE OF PATIENT / LEGAL REP**: _____ **DATE**: _____
If signed by a person other than the patient, complete the following:
1. Individual is: a minor legally incompetent or incapacitated deceased
2. Legal authority: parent* legal guardian next of kin / executor of deceased activated POA for Health Care
* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only:
Signature/ID verified Yes No
Completed by: _____ Date released _____