AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

The undersigned hereby authorizes the release of medical information as follows:

Patient Name _____
First Middle Last

_____
Address City, State, Zip

_____
Birth date SSN Phone

I authorize Ophthalmic Surgeons and Consultants of Ohio, Inc. and/or

Dr. _____

to release information regarding my medical care and treatment to:

_____

_____

_____

Information to be released:

- ☐ All care and treatment records (Does not include tests unless specified below)

Include the following:

☐ Operative Reports ☐ Allergy Records ☐ Office Notes ☐ Lab Reports ☐ Visual Fields ☐ Other **(specify)**

Special Note: I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information which may relate to ALCOHOL AND DRUG ABUSE, PSYCHIATRIC DISORDERS AND TREATMENT, AIDS and/or HIV TESTING and/or OTHER SEXUALLY TRANSMITTED DISEASES. I specifically consent to release and disclosure of this information, including transmission of my records via a facsimile (fax) machine. Subsequent transfer of my medical records or disclosure of their content is prohibited without my specific consent.

I UNDERSTAND THAT THERE ARE CHARGES FOR THE COPYING OF MY MEDICAL RECORDS. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYING THESE CHARGES PRIOR TO THE RELEASE OF MY MEDICAL RECORDS. I UNDERSTAND THAT I WILL BE CONTACTED PRIOR TO THE COPYING OF MY RECORDS TO INFORM ME OF THE CHARGES, AT WHICH TIME I MAY CANCEL THE RELEASE OF MY RECORDS.

_____

_____ _____
Signature of Patient or Authorized Representative Date

This authorization expires 90 days after the date signed