



**PEDIATRIC OPHTHALMOLOGY  
& ADULT STRABISMUS**

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**Medical Records Release**

\_\_\_\_\_  
(Name of Patient) (Birthdate)

\_\_\_\_\_  
(Street Address) (City, State, ZIP Code)

**Authorizes:**

**Release of Records to:**

\_\_\_\_\_  
(Name of Physician) (Name of Physician)

\_\_\_\_\_  
(Name of Health Care Facility) (Name of Health Care Facility)

\_\_\_\_\_  
(Street Address) (Street Address)

\_\_\_\_\_  
(City, State, ZIP Code) (City, State, ZIP Code)

**Information to be Released:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> All Clinic Records | <input type="checkbox"/> Visual Fields | <input type="checkbox"/> Lab Reports     |
| <input type="checkbox"/> Office Notes       | <input type="checkbox"/> X-Ray Reports | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Photographs        |  |  |

List other facilities records to be included when releasing for the purpose of continuing medical care:

**For the Following Dates:** \_\_\_\_\_

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Mental health              | <input type="checkbox"/> AIDS test results              | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Developmental disabilities | <input type="checkbox"/> Aids-related disease diagnosis | <input type="checkbox"/> Other      |
| <input type="checkbox"/> Alcoholism                 |   |                                     |

**Purpose or need for disclosure:** (check applicable categories)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Further medical care      | <input type="checkbox"/> Payment of insurance claim           | <input type="checkbox"/> Legal investigation |
| <input type="checkbox"/> Application for insurance | <input type="checkbox"/> Vocational rehabilitation evaluation | <input type="checkbox"/> Personal            |
| <input type="checkbox"/> Disability determination  |   | <input type="checkbox"/> Other               |

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records. \_\_\_\_\_

(Alternate date if not one (1) year)

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

**Signature of Patient** \_\_\_\_\_ **Date** \_\_\_\_\_

(If signed by person other than patient, state relationship and authorization to do so)

\_\_\_\_\_  
(Authorized signature)

**Patient is:**  Minor  Incompetent  Disabled  Deceased

**Legal Authority:**  Legal  Legal guardian  Next of kin of deceased