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AUTHORIZATION TO REQUEST OR RELEASE MEDICAL INFORMATION

PATIENT: _____
LAST NAME FIRST NAME

I AUTHORIZE: _____
HEALTHCARE PROVIDER

_____
ADDRESS

_____
CITY STATE ZIP CODE

TO RELEASE TO: _____
NAME OF RECEPIENT

_____
ADDRESS

_____
CITY STATE ZIP CODE

I AM REQUESTING COPIES OF THE FOLLOWING INFORMATION FROM MY MEDICAL RECORD: (Please check box below)

- O COMPLETE MEDICAL RECORD
- O X-RAY/ LABORATORY TEST (SPECIFY): _____
- O RECORDS PERTINENT ONLY TO MY ILLNESS: _____
- O HISTORY AND PHYSICAL EXAM (DATE):_____
- O OTHER: _____
- O **HIV RECORDS**
- O **MENTAL HEALTH**
- O **ALCOHOL/SUBSTANCE ABUSE RECORDS**

Orlando Eye Institute is hereby released from all legal liability that may arise from the release of the information requested. I understand that this information is to be disclosed for the following purpose and that purpose only.

This authorization shall expire 60 days from the date below. It may be revoked in writing at anytime.

Patient Signature: _____ DATE: _____

_____DOB:_____
ADDRESS

_____
CITY STATE ZIP CODE