



4324 Veterans Blvd, Suites 102, 104 & 108
Metairie, LA 70006
Phone (504) 455-9825 Fax (504) 309-2600

Authorization for Release of Medical Information

Patient's name: _____ Date of Birth: _____
Address: _____
City/State/Zip Code: _____
SS#: _____ Patient's phone #: () _____
Date of Request: _____ Date Needed: _____

<input type="checkbox"/> I authorize Eyecare Associates to release information to: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)	OR	<input type="checkbox"/> I authorize Eyecare Associates to obtain information from: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone #/Fax # (include area code)
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PURPOSE FOR THIS REQUEST: (Check one.) Healthcare Insurance coverage Personal Other
 Transfer of Care Moved out of state

TYPE OF RECORDS REQUESTED: (Check one.)

All medical records related to a specific illness or injury.

Specify illness/injury _____ Date(s) of treatment _____

- Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)
- Specific information (Select one or more, as applicable)
 - Clinic notes Visual fields Contact Lens Information Laboratory test results
 - Photos Other _____ (Please describe.)
- Entire copy of the record checked above.

AUTHORIZATION VALID FOR: (Check one.)

- This request only.
- One year from the date of this authorization.

I understand that:

- My right to healthcare treatment is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- There may be a charge for the requested records.

NOTE: Medical records are faxed in cases of medical necessity only.

Signature of Patient or Representative _____ Date _____

Relationship to Patient (if requester is not the patient) _____

Distribution: Original to medical record. Copy to requester, as required.