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:** _____

☐ I authorize Eyecare Associates **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

OR

☐ I authorize Eyecare Associates **to obtain information from**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (include area code)

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.