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**:	OR	☐ I authorize Eyecare Associates **to obtain information from**:
Name of Provider or Facility		Name of Provider or Facility
Address		Address
City, State, Zip Code		City, State, Zip Code
Phone #/Fax # (include area 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.