Authorization for Release of Medical Records

Bowden Eye & Associates

Please email completed forms to medicalrecords@eyehealthamerica.com and allow 3-5 business days to process.

Patient Information

Date of Request: _____

Patient Name: _____
Date of Birth: _____
Street Address:
_____

City/State/Zip:
_____
Phone Number: _____
Email Address: _____

Authorization Details

I authorize the disclosure of specific health information from the records of the above-named patient as indicated below *(select one or more):*

☐ Entire Medical Record ☐ Imaging / Lab Reports ☐ Other (Specify):
☐ Office Notes ☐ Operative Reports _____

This authorization is confined to the following dates of treatment: _____

Release Information

Records to be Released From *(clinic & location)*: _____

Records to be Sent To:

Recipient Name: _____ Phone: _____
Address: _____ Fax: _____
City/State/Zip: _____ Email: _____

Delivery Method: *(mailed records may incur processing fees if sent to an individual's home address)*:
☐ Clinic Pick-up ☐ Fax ☐ Email ☐ Mail ☐ Patient Portal

I understand that if my health information is disclosed to a party other than a healthcare provider, health plan, or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations. If the health information that I have requested contains any privilege psychiatric or psychological information related in the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as AIDS/HIV, Aids-Related Complex, Venereal Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release the releasing facility indicated above, and their officers, trustees, agents, and employees from any and all liabilities, damages, and claims, which might arise from the release of the health information authorized by me above.

Expiration: This authorization will expire 1 year from the date of signature

Signature of Patient *(or Representative):* _____
Date: _____ Representative Name & Relationship: _____

CONFIDENTIAL HEALTH INFORMATION ATTACHED

Protected Health Information is personal and sensitive information related to an individual's health care. It is being transmitted to you by facsimile or email after appropriate authorization from the patient or under circumstances that do not require patient authorization. You as the recipient are obligated to maintain this information in a safe, secure and confidential manner. Re-disclosure of this information without additional patient consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law. If you have received this message in error, please notify the sender to arrange for return or destruction of these documents.