FICHTE ENDL & ELMER EYECARE
AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Name: _____ Date of Birth: _____ Tel No: _____

Street Address_____

City: _____ State: _____ Zip Code: _____

The specific information that I wish to have released is:

_____ All Clinical Medical Records

_____ All Records – Please list (e.g., billing, angiograms, photographs, etc.): _____

_____

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion or mental health treatment.** Separate consent must be given before this information can be released.

_____ I consent to have the above information released.

_____ I do not consent to have the above information released.

Signature: _____ Date: _____
(Parent or Legal Guardian of Minor)

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment.**

_____ I consent to have the above information released.

_____ I do not consent to have the above information released.

Signature: _____ Date: _____
(Parent or Legal Guardian of Minor)

I understand that this authorization is valid for a _____ day period from the date that is signed. I may revoke this consent at any time through written notice.

Signature: _____ Date: _____
(Parent or Legal Guardian of Minor)

The cost to release medical records is $.75 per page; however, if medical records are released to a physician for the continuance of care this fee is waived.

Release Records to:

Name: _____ Tel : _____ Fax:_____

Street Address_____

City:_____ State: _____ Zip Code: _____