FLORAL PARK OPHTHALMOLOGY

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Release of Medical Records

I hereby request a copy of my medical records for ____ myself or for ____ review by another provider. I understand that this information is confidential and will only be released as specified in this authorization. This authorization is valid from __________ (Today's Date) and until __________ (End Date).

I also understand that by making this request, any HIV related information contained in my medical record will also be released to the specific party.

This release does not include authorization of any drug and alcohol treatment related records.

I also understand that a copying fee of $.75/ page will be charged to process this request.

PATIENT INFORMATION (Please print clearly):

Name ____________________ (Last) First ______________ MI ______________

Address ____________________ City ______________ State/ Zip ____________

Phone ____________________ (Home) Date of Birth ____________________

INFORMATION TO BE RELEASED:

Office Visits- Date (s) ____

Other – Date(s) ____

INFORMATION TO BE RELEASED TO:

Provider ____
Name Phone

Address ____

INFORMATION TO BE RELEASED FROM:

Provider ____
Name Phone

Address ____

____
Signature of Patient or Legal Guardian Date