VCS | VISION CARE SPECIALISTS

PATIENT REQUEST FOR HEALTH INFORMATION

Patient Information (Please Print)

Patient Name: ______________________________ Date of Birth: ________________

Name at Time of Treatment (if different than above): ______________________________

Phone (H): ____________ Phone (M): ____________ E-mail: ________________

Street Address: ______________________ City/State/Zip: ______________________

Above listed patient authorizes Vision Care Specialists, Inc. to make health information disclosure per options checked below (check appropriate boxes):

Medical Record

☐ 2 years prior from last date seen

☐ Dates Other:______________________________

☐ Test Images (Optos, OCT, Visual Field) Please specify:

RESTRICTIONS: Only health information originated by Vision Care Specialists, Inc. will be copied unless otherwise requested. This authorization is valid only for the release of health information dated prior to and including the date on this authorization unless other dates are specified. VCS has up to 30 days from the receipt of this signed request to process and release the requested information.

Vision Care Specialists should release my health information to ☐ **Self**

Paper: ☐ Home Delivery ☐ In-Person Pickup ☐ Other (complete section below)

Electronic: ☐ Email*

*Email services are encrypted and require the recipient to create an account to access the encrypted email. Instructions are provided when the email is sent.

Vision Care Specialists should release my health information to ☐ **Other:**

Recipient Name: ______________________________

Full Address: ______________________________

Fax: ________________ Phone: ________________

☐ **Please mail records**

☐ **Please fax records**

(We do not email to a third party)

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Vision Care Specialists, Inc. I understand that the revocation will not apply to the information that has already been released in response to this authorization. **This authorization will automatically expire 1 year from the date signed.**

I have read the above foregoing Authorization for Release of Health Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X ______________________________ ________________

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

______________________________ ________________

Printed name of Authorized Representative

Relationship / Capacity to Patient

____

Address and telephone number of Authorized Representative

Internal Use Only

Patient Account #______________________

______________________________ ________________

Doctor's Signature (Medical Records Only)

Completed by / Date Completed