AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:_______________________________________

Address:_______________________________________

Date of Birth:_______________________________________

Phone Number:_______________________________________

AUTHORIZATION SECTION

I, _______________________________________ (print name), authorize and request the disclosure of my
■ Entire Medical Record ■ Specific Date Range ________to_______ ■ Other_______________ be released:

FROM:
Michigan Eyecare Institute
29877 Telegraph Rd. Ste. 100
Southfield, MI 48034
P: (248) 352-2806 F: (248) 352-9590

TO:____
____
____

For the purpose of:____

I understand that:

1. The information disclosed under this authorization might be re-disclosed to additional parties and may no longer be protected by federal or state law.
2. That I may revoke this authorization at any time by signing/dating a revocation statement and returning it to Michigan Eyecare Institute Records Department, 29877 Telegraph Rd. Ste 100, Southfield, MI 48034. I further understand that such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.
3. This authorization will automatically expire 6 months from the signature date.
4. I agree to be responsible for the cost of copying these records at the rate stated below.

I further understand that I am under no obligation to sign this authorization and that my ability to obtain treatment, my eligibility for benefits, etc. will not depend in any way on whether I sign this authorization or not. A copy or facsimile of my signature shall serve as an original.

■ I will pick up ■ Mail ■ Fax Fax Number:__________________________________

I agree to pay for the release of records as follows:
$1.25 per page for the first 20 pages
$0.63 per page for pages 21-50
$0.25 per page for pages 51+

Fee Total:_________________________

____
Signature of Patient/Guardian/Authorized Representative

____
Date