Authorization for Release of Records

Patient Information:

Name (Printed) _____ Date of Birth _____

Information To Be Released From:

Name of Practice _____

Information To Be Sent To:

Palmer Eye Care, PC
127 S. 4th Street
PO Box 389
Albion, NE 68620
Phone: (402) 395-2082
Fax: (402) 741-3400

Information To Be Released:

- ☐ Most recent eye exam notes (Exam and Special Testing)
- ☐ Last 3 (or most recent) years of eye exam notes (Exam and Special Testing)
- ☐ Other: (Please Specify):_____

Patient Authorization:

I understand that my records may contain information regarding a diagnosis or treatment. I authorize the use or disclosure of the above specified information to be retrieved for medical purposes only.

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. I understand that if I am using an electronic signature that it is legally equivalent to my own signature under the ESIGN law of 2000.

Signature: _____ Date: _____

(Patient, Guardian, or Authorized Representative)

This authorization will expire 90 days from the date signed.