Authorization to Release or Obtain Health Care Information

Patient Name:________________________________ Date of Birth:____________________

Are medical records under another name?______________________ Phone Number:_____________

INFORMATION TO BE RELEASED ***BY:***	INFORMATION TO BE RELEASED ***TO:***
☐ Eye Physicians of Northampton ☐ __________________________________ Organization/ Person Name __________________________________ Street Address __________________________________ City, State, Zip __________________________________ Phone Fax	☐ Eye Physicians of Northampton ☐ __________________________________ Organization/ Person Name __________________________________ Street Address __________________________________ City, State, Zip __________________________________ Phone Fax

TYPE OF MEDICAL RECORDS REQUESTED:

☐ Most recent date of service

☐ Complete medical record abstract (includes 3 years of chart notes, most recent labs/ pathology & diagnostic imaging reports).

☐ My health information only for the following date(s):______________________________

☐ Diagnostic imaging/ photos

☐ Other:____

SENSITIVE INFORMATION: This authorization includes the release of the following sensitive information unless specifically excluded. Please circle if you do not want this released:

Mental Health HIV/AIDS Sexually Transmitted diseases Drug & Alcohol treatment

REASON FOR REQUEST: Personal Transfer of Care Disability Insurance

☐ Other (please explain):____

My Rights

- I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment).
- I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Eye Physicians of Northampton or another organization based upon this authorization.
- Authorization expires in 90 days.

____ ____________________

Patient or legally authorized individual signature Date

____ ____________________

Printed name if signed on behalf of the patient Relationship