JOYCE M. NATIONS, O.D., M.P.H. • LEIGHANN M. KURTH, O.D. & ASSOCIATES

# Medical Records Release

Patient Information:

| Full Name: | Phone: |
|---|---|
| Address 1: | DOB: |
| Address 2: | SSN# |
| City and State: | Zip: |

| Request Records From: | Send Records To: |
|---|---|
| Doctor/Clinic Name: | Doctor/Clinic Name: |
| Address 1: | Address 1: |
| Address 2: | Address 2 : |
| City, State, Zip: | City, State, Zip: |
| Phone: | Phone: |
| Fax: | Fax: |

Expiration date or event: ______________________

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. You can also review your health information that we have on file, before deciding whether to sign this authorization. Our ***Notice of Privacy Policies*** explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office to initiate the process.

If you sign this authorization, you can revoke it later, except if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office.

When your health information is disclosed as provided in this authorization, the recipient has no duty to protect its confidentiality. The recipient may re-disclose the information as he/she wishes.

We will not receive a financial benefit from disclosing this health information about you.

I have read and understand the form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

Signature: ________________________________ Date: ________________
(Patient or Legal Guardian)

Witness: ________________________________ Date: ________________
(Staff Member)

**Please send all medical records as soon as possible**

The records are to be: Mailed ______ Picked Up ______ Faxed ______

Completed By: ____________________ Date: __________

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