FLORIDA EYE INSTITUTE

Life is Looking Better Already

Authorization for Release of Medical Information

Patient Name: _____

Date of Birth: _____ **Phone:** _____

Address: _____

_____

I hereby authorize Florida Eye Institute to release my medical records to:

Person or Organization: _____

Street Address: _____

City/State/Zip Code: _____

Phone/fax: _____

Information to be:

_____ Mailed

_____ Faxed

_____ Pick up _____

(Date)

Patient rights with this authorization:

- I have the right to inspect and receive a copy of my health information as authorized by this request.
- I understand that there will be a copy fee for any records from my chart.
  - $1.00 per page for the first 25 pages
  - $ .25 per page for each additional page
- I understand that I am required to pay the fee in full before I obtain the copy.
- Florida Eye Institute has the right to maintain my permanent health record as defined by in Section 164.501 of the Code of Federal Regulations.
- Florida Eye Institute is allowed up to 30 days to comply with my request for information maintained on-site, and 60 days if information is maintained off-site.

I authorize Florida Eye Institute to copy and release my medical records:

_____

Patient / Guardian Signature **Date**

For Office Use Only: Physician Acknowledgement: _____

Date released: _____ *# of pages:* _____

Amount Due: _____ *Paid:* _____ *Completed by:* _____