713 N 114th St.
Omaha, NE 68154
Phone: 402-991-3131
Fax: 402-991-3151
Email: amy@provision-eyecare.com

provision EYECARE

Release of Medical Records

Patient Name: _____ DOB: _____

Address: _____
City State Zip Code

Phone: _____

I hereby authorize and request the release of my medical records:

FROM: _____

TO: _____

Purpose of Release: Medical Care Transferring Care Personal Records Attorney

Information to be disclosed: _____

From (Date): _____ To (Date): _____

This statement of consent can be revoked at any time before disclosure of the information, and expires on _____ (expiration date of event). If no expiration date or identifiable event related to the individual is listed, then the authorization expires 12 months after it is signed.

I understand that the individual/institute that receives the information described above may not be covered by federal privacy regulation, and that the information may be redisclosed publicly and no longer be protected by those regulations.

Patient Signature: _____ Date: _____
Or Signature of Parent, Guardian or Authorized Representative

Witness: _____ Date: _____