THE EYE STUDIO

eyecare + eyewear

Medical Release Form

INFORMATION TO BE DISCLOSED TO:

The Eye Studio T: 850-563-8800 F: 850-563-8801

651 Grand Panama Blvd # 105, Panama City Beach, FL 32407

I specifically authorize release of information relating to: (initial selection) ☐ General Medical Record(s), ☐ Progress Notes ☐ History and Physical Results ☐ Consultations ☐ Diagnostic Test Results ☐ Rx

☐(Specify):_____

_____

Name (First, Last): _____

Date Of Birth: _____ Phone Number: _____

Client/Representative: _____DATE: _____

INFORMATION TO BE RELEASED FROM:

Office: _____Phone#: _____

Address: _____Fax#: _____

This authorization will expire twelve (12) months from the date on which it was signed. REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations. CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form. REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid, and Medicare.