MACHA FAMILY EYE CARE, PC

1537 S. Scatterfield Rd. Anderson, IN 46016
Phone: 765-649-1200 | Fax: 765-649-4040

RECORDS RELEASE AUTHORIZATION

Patient Name _____

Date of Birth _____

Patient Address _____

Patient Phone Number _____

Release Records from: _____

Release Records to: _____

Purpose for this release: _____

Expiration date or event relating to the individual or purpose for the release: _____

Information you do NOT wish to be disclosed: _____

_____

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you refuse to sign this authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect it's confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility. (For marketing authorizations, include, as applicable: We will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.)

I authorize the professional office mentioned above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services). I HAVE READ AND UNDERSTAND THIS FORM, AND I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____ _____

Patient Signature Date

_____

Parent/responsible Signature (If patient is under 18 or you are a representative for patient)

S:_Daily Docs_\records release form.doc