CARDELLINO
eyecare & optical

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient name:_____.

Patient date of birth:_____.

Patient signature:_____.

Authorized Representative Signature:_____.

Date:_____.

I request and give authority to:

(Person/Office requesting information)-_____.

To obtain records from:

(Person/Office that has information)-_____.

Dates and Type of Information to be disclosed:

_____ 2 years prior to last date seen

_____records dating from _____to_____.

_____all medical records

_____specific information requested (example-any special testing or bloodwork results)

Any authorization you provide to us regarding the use and disclosure of your health information may be revoked by you in writing at any time. After you revoke your authorization, we will no longer use or disclose your health information for the reasons described in the authorization. However, we are generally unable to retract any disclosures that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for services received by you prior to the date you revoked your authorization.