PEDIATRIC Ophthalmology CONSULTANTS, LLC.

PEDIATRIC OPHTHALMOLOGY CONSULTANTS
AUTHORIZATION FOR RELEASE OF RECORDS

_____ PATIENT'S NAME

_____/_____/_____ DATE OF BIRTH

_____/_____/_____ DATE

_____ ADDRESS

(__ __ __) - __ __ __ - __ __ __ __ PHONE NUMBER

__ __ __ - __ __ - __ __ __ __ SOCIAL SECURITY NUMBER

THE SPECIFIC INFORMATION THAT I WISH TO HAVE RELEASED IS:

☐ All Clinical Medical Records
☐ Other Records - Please list (e.g. billing, photographs, etc.)

_____ _____ _____

_____ _____ _____

_____ SIGNATURE (PARENT OR LEGAL GUARDIAN OF MINOR)

_____/_____/_____ DATE

This medical record may contain information about:

☐ PHYICAL OR SEXUAL ABUSE
☐ ALCOHOLISM
☐ DRUG ABUSE
☐ HIV TESTING AND OR AIDS
☐ SEXUALLY TRANSMITTED DISEASES
☐ MENTAL HEALTH TREATMENT

Separate consent must be given before this information can be released. Please check only the boxes for which you are giving permission.

☐ I consent to have the above information released.
☐ I do not consent to have the above information released.

_____ SIGNATURE (PARENT OR LEGAL GUARDIAN OF MINOR)

_____/_____/_____ DATE

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once Pediatric Ophthalmology Consultants, L.L.C. discloses it to another party. I understand that this authorization is valid from the date that it is signed. I may revoke this consent at any time through written notice.

RECORD RELEASE TO

_____ NAME

(__ __ __) - __ __ __ - __ __ __ __ PHONE NUMBER

_____ STREET ADDRESS

_____ CITY STATE ZIP CODE

RECORD RELEASE FROM

_____ NAME

(__ __ __) - __ __ __ - __ __ __ __ PHONE NUMBER

_____ STREET ADDRESS

_____ CITY STATE ZIP CODE

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