KERRY SOLOMON, MD
CAROLINA EYECARE PHYSICIANS

CONSENT TO RELEASE/DISCLOSE PATIENT RECORDS/MEDICAL INFORMATION

Please Print All Information Unless Otherwise Noted

(Please Check One)

Request _____ Requesting information from another provider to us
Release _____ Releasing information from us to you or your provider

Requesting my protected health information from the following physician, / person, / facility:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____

Patient's Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Patient's Phone Number: _____

By signing this form, I am requesting and authorizing you to release and transfer confidential health information about me to the physician, / person, / facility listed below.

Release my protected health information to the following physician, / person, / facility:

Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____

For the following Dates: _____
List other facilities records that are to be included when releasing information for the purpose of continuing medical care:

_____

I am authorizing for the following information to be released:

☐ Eye Records ☐ History & Physical ☐ Lab Reports ☐ Photographs
☐ Operative Reports ☐ Pathology Reports ☐ Visual Field Reports ☐ Other (Specify Below)

_____

I am NOT authorizing information pertaining to: _____
_____ to be released.

- I understand this authorization will automatically expire one year from the date signed but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and receive a copy of the information that is to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and or may be unable to provide me with the most appropriate care.
- I understand that the release of information may NOT be re-released to any other person or organization without my consent.

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

_____ _____
Print Name of Patient or Personal Representative Date

_____ _____
Signature of Patient or Personal Representative Description of Personal Representative's Authority

NOTICE TO THE RECIPIENT OF THIS INFORMATION:
The patient information that you have been forwarded is confidential. Release or disclosure of this information is prohibited unless you have received authorization and written consent from the above patient.