Peninsula Eye Physicians

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Authorization to Release / Obtain Patient Medical Information

Please note: There is a $30:00 fee for copying medical records up to 10 pages.

After 10 pages, the fee will be $50:00 for all records on a USB drive.

I hereby authorize Peninsula Eye Physicians to release / obtain my medical information as listed:

Patient Name: _____ DOB: _____

Address: _____ City_____ State_____ Zip_____

Phone Number: _____

OBTAIN FROM:

_____
NAME

_____
ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE / FAX

RELEASE TO:

_____
NAME

_____
ADDRESS

_____
CITY, STATE, ZIP

_____
PHONE / FAX

Information Requested:

____ Entire EYE Record
____ Lab Results
____ X-Ray Results
____ Last Exam
____ Other_____

Specified Dates:

From :_____

To:_____

I UNDERSTAND THAT THIS AUTHORIZATION IS VALID FOR 90 DAYS AND MAY BE REVOKED IN WRITING AT ANY TIME PRIOR TO 14 DAYS BY NOTIFYING MEDICAL RECORDS.

_____ _____
Signature of Patient or legally responsible party ***Date of request***

_____ _____
Date received ***Date records mailed / e-faxed***