MEDICAL RECORDS RELEASE

Name of Patient: DOB:

Street Address: City, State Zip: ,

AUTHORIZES:

Physician Name:

Facility Name:

Address:

City, State, Zip:

RELEASE RECORDS TO:

Cascade Ophthalmology, P.C.
791 Kenmoor Ave SE – Suite A
Grand Rapids, MI 49546
Fax: 616-954-9622

INFORMATION TO BE RELEASED:

[X] All Clinic Records	[X] Visual Fields	[ ] Allergy Records
[X] Eye Records	[ ] X-Ray Reports	[ ] Lab Reports
[X] Office Notes	[ ] Immunization Records	[ ] Electrocardiograms
[X] Photographs	[ ] X-Ray Films (Specify)	[ ] Other (specify

List other facilities records to be included when releasing for the purpose of continuing medical care:

For the Following Dates: **ALL RECORDS**

In compliance with state statues which require special permission to release otherwise privileged information, please release records pertaining to:

[ ] Mental Health	[ ] AIDS test results	[ ] Drug abuse
[ ] Developmental disabilities	[ ] AIDS-related disease diagnosis	[ ] Other

Purpose or need for disclosure:

[X] Further medical care	[ ] Payment of insurance claim	[ ] Legal investigation
[ ] Application for insurance	[ ] Vocational rehabilitation eval	[ ] Personal
[ ] Disability determination	[ ] Other	

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records. _____
(Alternate date if not one (1) year)

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

Signature of patient: X_____ **Date** _____
(If signed by person other than patient, state relationship and authorization to do so)

Authorized Signature: _____ Relationship: _____

Patient is:	[ ] Minor	[ ] Incompetent	[ ] Disabled	[ ] Deceased
Legal authority:	[ ] Legal	[ ] Legal guardian	[ ] Next of kin of deceased	