



**Authorization to Obtain Medical Records**

I, \_\_\_\_\_, authorize Visions Medical Center to obtain the following health information, including copies of medical records regarding my care, from the following individuals/institutions:

<b>Information</b>	<b>Individual/Facility</b>	<b>Duration of Authorization</b>
Specific records, results, etc. you would like released	Name of the individual/facility you are authorizing to release your records	Please circle or indicate below the desired duration of this authorization
		One Time   Indefinite   Ending on / /
		One Time   Indefinite   Ending on / /
		One Time   Indefinite   Ending on / /
		One Time   Indefinite   Ending on / /
		One Time   Indefinite   Ending on / /

**Individual or Individual's Personal Representative  
MUST read and initial the following statements.**

I understand that Visions Medical Center will not condition my treatment, (and applicable; payment for my health care, my enrollment in a health plan or eligibility for benefits) on whether I provide authorization for the requested use and disclosure – except in limited circumstances (e.g., if the treatment is research-related or the treatment is necessary for the purpose of creating protected health information for disclosure to a third party such as physical examinations for school, camp, or employment purposes).

INITIALS: \_\_\_\_\_

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing. I understand that such revocation does not affect any action taken by Visions Medical Center before Visions Medical Center received my written notice.

INITIALS: \_\_\_\_\_

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations or other applicable state or federal laws.

INITIALS: \_\_\_\_\_

I understand that I may see a copy of the information described on this form if I ask for it, and that I may obtain a copy of this form after I sign it.

INITIALS: \_\_\_\_\_

I understand that this authorization is expires as I indicated under the "Duration of Authorization" section. If I indicated an indefinite length of authorization, I understand that this authorization is valid until I notify Visions Medical Center, in writing, of its revocation.

INITIALS: \_\_\_\_\_

I understand that this authorization is voluntary and I have the right to refuse to sign this authorization.

INITIALS: \_\_\_\_\_

I understand for my protection and in an effort to maintain the environment, my files will be transferred electronically and as such, incur a \$15 administrative fee assessed at the first appointment.

INITIALS: \_\_\_\_\_

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*Form must be completed before signing*

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Signature of Individual or Personal Representative of Individual

Date

Print Name of Individual: \_\_\_\_\_

Printed Name of Personal Representative: \_\_\_\_\_

Relationship of Personal Representative to Individual: \_\_\_\_\_

**\* YOU HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION \***