



Authorization to Release Medical Records

I, _____, authorize Visions Medical Center to release the following health information, including copies of medical records regarding my care, to the following individuals/institutions:

Information	Individual/Facility	Duration of Authorization
Specific records, results, etc. you would like released	Name of the individual/facility you are authorizing to receive 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: _____

Form must be completed before signing

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 *