COASTAL EYE CARE
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Phone 207-667-6300 / **Fax 207-667-9523**

Authorization to Release Healthcare Information

Patient Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

_____

☐ I, _____ hereby authorize Coastal Eye Care, its authorized employees or agents, to disclose and discuss records containing the following information TO_____ for the following dates of service _____.

☐ I, _____hereby authorize _____, and authorized employees or agents, to disclose and discuss records containing the following information **to Coastal Eye Care** for the following dates of service_____.

☐ Exam notes ☐ Test Results
☐ Other information to be disclosed (specify) _____

Name of Healthcare provider/ physician / facility _____

Address:_____Phone:_____

_____Fax:_____

Reason for release: ☐ Shared Care ☐ Transfer of Care ☐ Moved ☐ Other _____

I understand that my medical records contain information relating to my diagnosis and treatment and authorize the release of all such information listed above, except those items I have crossed out or specified. I further understand that I may review my records and refuse authorization to disclose all or some of the above health care information, but that refusal may result in improper diagnosis or treatment, denial of coverage or denial of a claim for health benefits or other insurance, or other adverse consequences. Records that are partial or incomplete will be labeled as such.

This Authorization expires 12 months from this date. However, I understand that I can revoke this authorization at any time prior to the above date by notifying Coastal Eye Care of the revocation. Such revocation must be in writing, signed, dated, and shall be effective when received, subject to the rights of any person who acted in reliance on the Authorization prior to receiving notice of revocation. I understand that revocation may be the basis of denial of health benefits or other insurance coverage or benefits.

Coastal Eye Care is not responsible for any re-release or misuse of the above requested information by the receiving party.

I (Do/Do Not) authorize release of HIV infection status information contained in the record.
Such information may not be re-disclosed by the recipient without my specific written consent.

I (Do/Do Not) authorize release of Alcohol or Drug abuse or Psychiatric information contained in the record. Such information may not be re-disclosed by the recipient without my specific written consent.

I understand that I am entitled to a copy of this authorization form.

_____ _____
Signature/Authorized Representative Date