

PEDIATRIC OPHTHALMOLOGY, P.A. AND THE CENTER FOR ADULT STRABISMUS

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Medical Records Release

(Name of Patient) (Birthdate)

(Street Address) (City, State, ZIP Code)

Authorizes:

Release of Records to:

(Name of Physician) (Name of Physician)

(Name of Health Care Facility) (Name of Health Care Facility)

(Street Address) (Street Address)

(City, State, ZIP Code) (City, State, ZIP Code)

Information to be Released:

- Checkboxes for: All Clinic Records, Office Notes, Photographs, Visual Fields, X-Ray Reports, Lab Reports, Other (Specify)

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

For the Following Dates:

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

- Checkboxes for: Mental health, Developmental disabilities, Alcoholism, AIDS test results, Aids-related disease diagnosis, Drug abuse, Other

Purpose or need for disclosure: (check applicable categories)

- Checkboxes for: Further medical care, Application for insurance, Disability determination, Payment of insurance claim, Vocational rehabilitation evaluation, Legal investigation, Personal, 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 Date (If signed by person other than patient, state relationship and authorization to do so)

(Authorized signature)

Patient is: Minor Incompetent Disabled Deceased

Legal Authority: Legal Legal guardian Next of kin of deceased