pediatrix | EYE CARE

AUTHORIZATION TO REQUEST HEALTH INFORMATION

Patient name: ______________________________ Date of birth.: ______________

INFORMATION REQUESTED BY (PATIENT)

Requestor name: ______________________________

Address: ______________________________ City: ______________ ZIP: ______________

Phone: ______________ Alt Phone: ______________ Email: ______________

PLEASE RETURN REQUESTED INFORMATION TO

Name: ______________________________

Address: ______________________________ City: ______________ ZIP: ______________

Phone: ______________ Fax: ______________ Email: ______________

The following information is requested:

- ❒ Most Recent examination notes
- ❒ Treatment dates from ______________ to ______________
- ❒ All records

I understand my consent is required to release any health care information related to testing, diagnosis and/or treatment for HIV, sexually transmitted disease, psychiatric disorders/mental health or drug and alcohol use. If I have been tested, diagnosed or treated for above conditions, Pediatrix Eye Care is specially authorized to release all health care information relating to such testing, diagnosis or treatment.

I understand that once the above information is disclosed, it may be disclosed further by the recipient, and the information may not be protected by federal privacy laws or regulations.

THIS AUTHORIZATION EXPIRES 90 DAYS AFTER THE DATE IT IS SIGNED

Signature:______________________________ Date:______________

Print name of requestor (if other than patient) ______________________________

Relationship to patient (if other than patient) ______________________________

STAFF ONLY
Processed by: Initials ______________ Date ______________ ❒Fax ❒Mail ❒Email