Family Eye Care Center & Optical Gallery

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Eye Physicians and Surgeons

Glaucoma
Cataracts
Diabetic Eye Disease
Laser Surgery

Authorization to Use and Disclose Health Information

Name: _____ Account: _____ Date: _____

DOB: _____ Patient Home #: _____ Patient Cell #: _____

I hereby authorize the Family Eye Care Center & Optical Gallery to release or obtain medical information to.from the individual/organization named below.

RECORDS RELEASED TO:	RECORDS OBTAINED FROM:
Name:	Name:
Street Address:	Street Address:
City/State/ZIP:	City/State/ZIP:

Treatment Dates:_____ Purpose of Request:_____

In compliance with Massachusetts Statutes which require specific authorization to release otherwise privileged information, please release records pertaining to: (check all that apply)

☐ Substance Abuse (drug/alcohol) Treatment
☐ Information related to sexually transmitted diseases
☐ Genetic Testing
☐ Domestic Violence Victims Counseling
☐ Sexual Assault Treatment
☐ HIV, AIDS or ARC Information
☐ Communication between me, my psychiatrist, psychologist, or other behavioral health professional.
☐ Abortion consents/records or family planning services
☐ Social Work Counceling/Therapy

I understand that Federal Privacy Laws may no longer protect the information furnished once it has been released.

I understand that I may revoke this authorization at any time, except that the revocation will not have any effect on any action taken by the Family Eye Care Center & Optical Gallery before the Family Eye Care Center & Optical Gallery received written notice of revocation. I further understand that I must provide any notice or revocation in writing to the Family Eye Care Center & Optical Gallery.

This authorization is in effect through (check one) ☐ ____/____/____ or ☐ NO Expiration unless revoked or terminated by the person or the patient's personal representative.

All Medical Records are released on a CD. The Family Eye Care Center & Optical Gallery charges a fee of $25 for the reproduction of medical records. Please allow approximately 14 business days for the records to be available.

Signature of patient or legal guardian: _____Date:_____

Print name and relationship if other than Patient: _____

Date released:_____/_____/_____ Released By:_____