ALTA EYE CARE - Authorization to Release Medical Records

3239 Stevens Creek Blvd., San Jose, CA 95117 408. 502.6188 Fax 888. 456.8575

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_____ _____
Patient Name Guardian or Authorized Party Name (if applicable)

_____ _____
Date of Birth Contact Phone #

I authorize the use and disclosure of my health information on as described below:

Information Requested:

____ Records relating to treatment dates from: _____ to: _____

_XX_ Records for all care at this facility or by this doctor.- eye exams, Visual fields, photos, other imaging studies

____ Other (Please Specify)

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation; this consent will automatically expire in 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Information to be released:
[X] from [ ] to: _____

[ ] from [X] to: Alta Eye Care, 3239 Stevens Creek Blvd, San Jose, CA 95117 P (408) 502-6188 F(888) 456-8575
Email: Altaeye@Altaeye.com

_____ **(Initials of patient or guardian)** I understand that Alta Eye Care may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization.

_____ _____
Signature of Patient or Guardian ** Date

** If this authorization is signed by an individual's personal representative, the representative's authority is based on:
(e.g., state law, court order, etc.)
*A fax copy or photocopy of this consent shall be as valid as the original.

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse or psychological/psychiatric conditions, __ I DO __ DO NOT, authorize the release of this information.

_____

RECORDS FEE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction and transfer of records. **The fee is $25.00.**
Enclosed check # Visa or Mastercard Card # Exp.

For office use only:
Physician Authorization _____ Date sent: _____ By: _____