AUTHORIZATION TO RELEASE MEDICAL RECORDS

Denny Eye & Laser Center
711 Van Ness Ave., Suite 300 San Francisco, CA 94102
Phone: (415) 567-8200 Fax: (415) 567-2973

Please address office facility/entity from which records will be obtained

To / From: (circle one) _____

Address: _____

Phone:_____ **Fax:**_____

- □ Complete chart notes and test results which may be relevant to evaluation or treatment of the individual's eye health or vision issues
- □ Glasses prescription / contact lens prescription
- □ Other: _____

Records obtained with this authorization will be used for continuation of treatment, payment or healthcare operations

Patient Name: _____ **Date of Birth:** _____

Address: _____

Telephone: _____

While federal law establishes your right of access to medical records which pertain to you, the records themselves are the property of the individual organization which generated them. This means that, as the record keeper, we are responsible for maintaining and protecting your privacy to the best of our ability. Because insurance reimbursements to us do not cover administrative services, providing **personal copies** of these records or transfer of care to another physician's office is subject to a **$30 administrative fee**. *Unless*, requested by the physician's office directly. Records sent will include only those records generated by our practice, *not including information provided by the patient or by another care or service provider* (e.g. slides or photos, reports or notes prepared by other providers).

RELEASE OF ADDITIONAL RECORDS

This is because we have no way to ensure the accuracy and completeness of any records except those we generate, and we do not have the necessary equipment for duplicating photos, slides, or x-ray films. If you wish to have copies of documents we have received from other sources sent along with those by Denny Eye & Laser Center, this copying will be included in the administrative fee. I, _____, ADDITIONALLY request and authorize the DENNY EYE & LASER CENTER to release copies of **all documents** in the above-noted medical record to be sent as requested above. I indemnify and hold harmless the Denny Eye & Laser Center from any responsibility for the condition, accuracy, or completeness of any document or information not generated by them.

_____ _____

Signature of Patient or Authorized Representative **Date**

If signed by anyone other than the patient, the signer's authority is as _____.
This authorization expires 90 days from the date signed, unless revoked before that time by the patient's written request. The patient or signer may receive a copy of this authorization upon request.