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Davenport Eye Group
Keeping Your World in Focus

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Name: _____ **Phone:**_____

Address: _____ **DOB:** _____

_____

Authorizes:

_____
(Name of Physician)

_____
(Name of Healthcare Facility)

_____
(Street Address)

_____
(City, State, Zip Code)

Release of Records to:

_____
(Name of Physician)

_____
(Name of Healthcare Facility)

_____
(Street Address)

_____
(City, State, Zip Code)

Information to be Released:

- ❑ All Clinic Records
- ❑ Last few of visits
- ❑ Office Notes
- ❑ Photographs
- ❑ Visual Fields
- ❑ For the Following Dates: _____

Purpose or need for disclosure: (check applicable categories)

- ❑ 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 _____ Relationship _____

Patient is: ❑ Minor ❑ Incompetent ❑ Disabled ❑ Deceased

Legal Authority: ❑ Legal ❑ Legal guardian ❑ Next of kin of deceased

- ❑ **Please cancel any future appointments and/or recalls.**
- ❑ **I plan to keep my future appointment and/or wish to receive recalls.**