Medical Records Request Form

RE: Name_____
SS#_____
Account #_____
Date of Birth_____

Attn: Medical Records Personnel
_____
_____
_____

To whom it may concern:

I hereby authorize you to release and send copies of my medical records to LaserCare Eye Center.
Their address is: LaserCare Eye Center
440 W. Highway 635, Suite 300
Irving, Texas 75063

1) Doctor's office or clinic authorized to release medical record:_____
_____
_____

2) Description of information to be released:_____
_____

3) Date when this authorization expires:_____

- LaserCare Eye Center, P.A. seeks to protect its patient's protected health information and abides by Privacy Standards established by the Health Insurance Portability and Accountability Act of 1996.
- 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 send it to the address above.
- I understand that LaserCare Eye Center, P.A. cannot be held responsible for damages related to the release, faxing or mailing of Medical Records. I understand that it is possible that information disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Thank you,

Patient's signature_____ Date_____