

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
The Regional Eye Center

135 W Ravine Road, Suite 2C
Kingsport, TN 37660
Phone: 423-246-7372
Fax: 423-246-5038

I hereby authorize **The Regional Eye Center** and its physicians, employees and agents to release or disclose to the below-named recipient my medical records.

Patient Name: _____ Date of Birth: _____

Release of medical records to: _____

Address: _____

Contact: _____

Purpose of disclosure: _____

The authorization will expire on: _____
Date or Event, may not exceed one year

This request and authorization applies to:

_____ **All** medical records

_____ Health care information relating to the following treatment, condition, or dates of treatment:

_____ Specific records to be released (eg. Labs, imaging reports, other):

Unless otherwise requested, records will be electronically faxed to recipient.

Special Request Format: ___ Paper ___ Electronic Format (CD /Flash Drive)

If a fee is due for cost of processing this request, release will be completed after payment.

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

Patient Signature (or Authorized Representative)

Date Signed

Relationship to Patient, if applicable