

CO Corliss

OPTOMETRISTS

Kenneth J. Corliss, OD

MEDICAL RECORDS REQUEST

Date _____

Name of Patient _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Phone _____

Authorizes:

Name of Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Information to be Released:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> All clinic records | <input type="checkbox"/> Eye records | <input type="checkbox"/> Visual Fields | <input type="checkbox"/> Office notes |
| <input type="checkbox"/> Lab reports | <input type="checkbox"/> Photographs | <input type="checkbox"/> Allergy records | <input type="checkbox"/> X-Ray reports |
| <input type="checkbox"/> Immunization records | <input type="checkbox"/> Electrocardiograms | | |
| <input type="checkbox"/> X-Ray films (specify) _____ | <input type="checkbox"/> Other (specify) _____ | | |

List other facilities records to be including when releasing for continuing medical care:

For the following Dates: _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

- | | | | |
|---|---|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Mental health | <input type="checkbox"/> AIDS test results | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Developmental disabilities | <input type="checkbox"/> AIDS-related disease diagnosis | <input type="checkbox"/> Other | |

Purpose or need for disclosure: (check applicable categories)

- | | | |
|--|---|--|
| <input type="checkbox"/> Further medical care | <input type="checkbox"/> Payment of insurance claim | <input type="checkbox"/> Legal Investigation |
| <input type="checkbox"/> Application for insurance | <input type="checkbox"/> Vocational rehabilitation evaluation | <input type="checkbox"/> Personal |
| <input type="checkbox"/> Disability determination | <input type="checkbox"/> Other | |

I understand that this authorization shall be valid for one (1) year unless _____
otherwise stated at right or revoked through written notice to Medical Records. (alternate date if not one year)

I authorize release of my medical records in accordance with the specification listed above. I understand written notice is necessary to cancel this request.

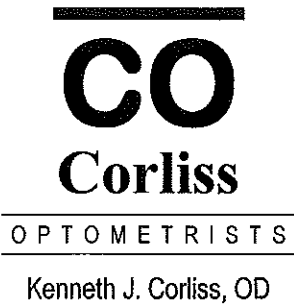
Signature of patient _____ Date _____

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



DISCLOSURE OF INFORMATION TO THIRD PARTY

Date: _____

Patient: _____

Your signature below authorizes our office to discuss your office information with regards to insurance and personal liability, diagnosis, medical history and treatment with persons listed herewith.

Name/Relationship _____ Phone # _____

Name/Relationship _____ Phone # _____

Name/Relationship _____ Phone # _____

Patient's Signature _____

CO

Corliss

OPTOMETRISTS

Kenneth J. Corliss, OD

RECORDS RELEASE

Date of Request: _____

Please release my records to the following doctor or clinic:

Patient's Name: _____

Date of Birth: _____

Patient's Signature _____