Harvard Eye Associates
23961 Calle de la Magdalena, #300
Laguna Hills, CA 92653
Phone: (949) 951-2020
Fax: (949) 356-1660

HARVARD EYE ASSOCIATES

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

Patient's email address: _____ **Fax:**_____
NOTE: Please allow up to 2 weeks for processing. Records will be mailed, unless otherwise specified.

Request release of information FROM:
Harvard Eye Associates: Medical Records
23961 Calle de la Magdalena, # 300
Laguna Hills, CA 92653
Phone: 949-951-2020 **Fax:** 949-356-1660

Request release of information TO:
Physician/Facility or Patient:_____
Street Address: _____
City/State:_____
Phone:_____ Fax:_____

For release of medical record information for additional minor children (ages 17 and under), list below:
Name(s):_____ Date(s) of Birth: _____

Please release the following information *(check all that apply)*
☐ Complete Medical Record
☐ Medical Records for Specific Dates of Service (please list):
from_____ to _____
☐ Other (please list)_____

Reason for Release *(check all that apply)*
☐ Continuing medical/surgical care
☐ Insurance
☐ Relocating
☐ Other *(please specify)*_____

This authorization remains in effect no longer than one year from the date of signature or until the following date or event:_____

All information regarding chemical dependency, mental health, alcohol abuse, HIV, or sickle cell anemia will be released unless you restrict here by checking the appropriate area and initialing your restrictive action. Please exclude:
☐ Chemical Dependency ☐ Mental Health ☐ Alcohol Abuse ☐ HIV ☐ Sickle Cell Anemia PLEASE INITIAL: _____

RIGHTS OF THE PATIENT:
I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPAA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

_____ _____
Name of Patient or Authorized Representative Date

_____
Signature of Patient or Authorized Representative