CONSULTING OPHTHALMOLOGISTS, P.C.

499 Farmington Avenue, Suite 100
Farmington, Connecticut 06032
Phone: (860) 678-0202

295 Western Boulevard
Glastonbury, Connecticut 06033
Fax: (860) 674-8838

Email: MedicalRecords@Consultingeye.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

1.) PATIENT INFORMATION: _____ _____ _____
Name | Date of Birth | Home Phone #

_____
Address | City | State | Zip Code

2.) AUTHORIZES:

_____
Name of Medical Office

_____
Address of Medical Office

3.) TO DISCLOSE TO:

❑ Self, Delivery Options: ❑ Pick up: ❑ View on Site ❑ Mail to address above
❑ To be picked up by, I hereby authorize_____ to pickup my records (Photo ID required)
❑ Send to: **Consulting Ophthalmologists, P.C., 499 Farmington Avenue, Suite 100, Farmington, CT 06032**
Name of Recipient & Mailing Address
860-678-0202 **860-674-8838**
Telephone # Fax # (if applicable)

4.) DATE(S) OF INFORMATION TO BE DISCLOSED: From _____(month/year) to _____(month/year)
If left blank, only information from the past two (2) years will be disclosed.

5.) INFORMATION TO BE DISCLOSED:

❑ All medical records related to (specify condition, treatment, etc.):_____
❑ All billing records related to (specify condition, treatment, etc.):_____
❑ Radiology films/images (specify test):_____
❑ Specific records/information as follows:_____
_____

6.) EXPIRATION: This authorization is good until the following date / event:_____
If left blank, the authorization will expire in one (1) year from the date signed.

7.) PURPOSE (check all that apply-**copy fees may apply):** ❑ Further Medical Care ❑ Legal Purposes
❑ Insurance Eligibility/Benefits ❑ Personal (at my request) ❑Other:_____

By signing below, you agree to the following:

1.) I understand that if my records contain documentation of alcohol abuse, psychiatric condition, drug abuse, or communicable diseases, this information will be released as part of my record.
2.) I understand that if the person or entity receiving this information is not covered by federal privacy regulations, this information is not covered by federal privacy regulations, this information will no longer be protected and may be re-disclosed.
3.) I understand that I may revoke this authorization at any time, but revocation will not apply to information that has already been released. Revocations should be sent to the address noted at the top of this form.
4.) I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
5.) I understand that there may be a charge for obtaining the requested information. Information on the charge can be obtained by contacting the medical records department noted at the top of this form.
6.) I understand that a copy or Fax of this document is just as valid as the original document.
7.) I understand that this authorization will expire one (1) year after signed unless an earlier date is specified here_____.

_____ _____ _____
Signature of Patient or Authorized Person | Date | Contact Telephone Number

_____ _____
Relationship of Authorized Person | Reason Patient is Unable to Sign Authorization

OFFICE USE ONLY:
Account #_____ Release Date:_____ Initials:_____

Revised 11/2019