AMERICAN VISION PARTNERS

VANTAGE EYE CENTER

AUTHORIZATION TO RELEASE/REQUEST HEALTH INFORMATION

Patient's Name	Date of Birth	Medical Record Number
Address		Phone Number

I hereby request access to the Protected Health Information ("PHI") record from this date: _____ to this date: _____ maintained or created by the provider named below to the recipient named below.

☐ Progress/Chart Notes
☐ Billing Records
☐ Entire health record
☐ Other: _____

Delivery of Records:
☐ I will pick up my records.
☐ Please send my records to the Patient Portal.
☐ Please fax my records to the number below.
☐ Please mail copies of my records to the address below.

	Records From	Records To
Name		
Address		
Phone		
Fax		

Purpose of Request:
☐ Patient's Request ☐ Referral/Continuing Medical Care ☐ Other: _____

By signing below, I understand:

- I may revoke this authorization at any time by providing my written revocation to the address at the bottom of this form. My revocation will not apply to information already retained, used, or disclosed in response to this authorization. Unless sooner revoked, the automatic expiration date of this authorization will be twelve (12) months from the date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, AVP may not condition the provision of treatment or payment for my care on my signing of this authorization.
- The information disclosed pursuant to this authorization may be redisclosed by the recipient and may not be protected under the HIPAA regulations.

Patient's Full Legal Name	Date of Birth
Signature of Patient/Parent/Legal Representative	Date

***** For Internal Use: Please retain a copy of this form for six (6) years.****
Identity of requestor verified via: ☐ Photo ID ☐ Matching Signature ☐ Other (specify): _____
Records Sent by (Print Name)_____on (date) _____