MEDICAL RECORDS RELEASE FORM

Request Date:__________________

Patient Name:____DOB:_____________

Additional Patient Name:_________________________________DOB:_____________

Patient Address:____

____

I hereby authorize a one-time release of my protected health information:

CIRCLE ONE		**CIRCLE ONE**	
TO FROM	Fox Chase Family Eye Care 7834 Oxford Avenue Philadelphia, PA 19111 P 215-745-0993 F 215-745-2168	TO FROM	_______________________ _______________________ _______________________ _______________________

Disclosures regarding records released from Fox Chase Family Eye Care:

* A fee of $25.00 for the first patient and $10.00 for each additional should accompany this request. An additional $10.00 handling fee for each patient will be assessed for records that are needed sooner than 15 days from the date of receipt. **Records will be delayed (not prepared) until payment is received.**
* Medical records will be released within fifteen (15) business days of receipt of this request.
    a. Records from other providers will not be released and may be obtained directly from that provider.
    b. Insurance explanations of benefits are available directly from your insurance company.
    c. Color documents, such as photographs and color printouts will only be released via email.
    d. Three years of records will be released unless determined to be medically necessary by your doctor.
* Individual written consent will be required for each adult listed above.
* Records may contain sensitive information, including information related to diseases you may have.

Patient Signature:____
(or signature of legal representative and attach evidence of authority)

Printed Name:____

RECEIVED:_________