Release of Records from Seacoast Vision Care

By signing this form, I authorize Seacoast Vision Care to release my confidential health information by releasing a copy of my medical records, or a summary or narrative of my protected health information to the physician/person/facility listed below:

Name: _____

Address: _____

Phone: _____ Fax: _____

Please provide records for the following dates:

From: _____ To: _____

I authorize the release of my complete health record with the exception of:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV/AIDS)
- ☐ Alcohol/drug abuse treatment

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient name: _____DOB: _____

Signature of Patient/Guarantor: _____

Date: _____