MEDICAL RECORDS REQUEST FORM

RE: NAME: _____ DATE: _____

DOB: _____

Attn: Medical Records Department

_____

_____

_____

To whom it may concern:

I hereby authorize you to release and send copies of my medical records to LaserCare Eye Center. Please use the following mailing address or fax#:

LaserCare Eye Center **Fax: 214 574-9601**
440 W. Hwy 635, Suite 300
Irving, Texas 75063

1. Doctor's office, clinic or institution authorized to release medical record:

_____

2. Description of information to be released: __All records__ Other:_____

3. Date when this authorization expires: _____

- LaserCare Eye Center, P.A. seeks to protect its patient's protected health information and abides by Privacy Standards established by the Health Insurance Portability and Accountability Act of 1996.
- I understand that I have the right to revoke this authorization, in writing, at any time, except:
  (1) where uses or disclosures have already been made based upon my original permission or
  (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest aclaim or the insurance policy.
- I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to the address above.
- I understand that LaserCare Eye Center, P.A. cannot be held responsible for damages related to the release, faxing or mailing of Medical Records. I understand that it is possible that information disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

Patient/Responsible Party Signature:_____

Date:_____