



Eye Specialists

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION (please print):

Patient Name: _____ Date of Birth: _____

Address: _____

City/State: _____ Zip Code: _____

Phone: _____ HOME CELL WORK

I authorize release of my health information from:

Physician/Facility: _____

Address: _____

City/State: _____ Zip Code: _____

Phone: _____ Fax: _____

Please send my health information to:

Physician/Facility: _____

Address: _____

City/State: _____ Zip Code: _____

Phone: _____ Fax: _____

Reason: Specialist Consultation Transfer of Care Moving Legal Personal Other (please describe): _____

Specific Information: (please check all that apply)

Recent H&P: _____ Last Three Visits: _____ Visual Fields: _____ OCT Testing: _____

Complete Records: _____ Other: _____

Your agreement will be requested in advance for any copying or mailing fees that the practice incurs to fulfill your request. Under Nebraska State Law, providers are allowed to charge a flat rate of \$20.00 plus 50¢ per page for sending medical records. You will be notified if this fee will be assessed prior to any records being released. The state law also states that a provider has up to 30 days to release your medical records. This practice has the right to deny access, in whole or in part, to protected health information if the records are psychiatric notes, are a matter of national security or public health policy, are part of legal proceedings we provided by a non-provider under promise of confidentiality concerning their identity, or could place in danger your life or the lives of others.

Please note date here if records are needed by a certain time: _____

Signature of Patient/Personal Representative: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____