PERMISSION TO RELEASE PATIENT MEDICAL RECORDS

TODAY'S DATE: ________________________________

PATIENT NAME (printed):____

DATE OF BIRTH: ____

I hereby authorize the release of my medical records or copies of such, including reports and/or testing associated with any previously diagnosed conditions and request they be transferred:

TO / FROM: **ELMQUIST EYE GROUP**
Trevor Elmquist, D.O., Kate Wagner, O.D., Nina Burt, O.D., Sarah Eccles-Brown, M.D.
12670 New Brittany Blvd., Suite 102
Fort Myers, FL 33907
PH (239) 936-2020 FAX (239) 936-2776
www.elmquist.com

TO / FROM: ____

____

____

PATIENT SIGNATURE: ______________________________________ DATE: ______________________

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 a claim 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 without my express revocation; this consent will automatically expire in 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by Federal Privacy Standards.

For office use only: Date Records Sent or Signed For: ________________________ By: _____________