Aurora EYE CLINIC

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

RELEASE INSTRUCTIONS

☐ I authorize Aurora Eye Clinic to send a copy of my medical records to:

☐ I authorize Aurora Eye Clinic to request a copy of my medical records from:

Name of Physician or Health Care Facility	City	State	Zip Code

Phone	Fax	Email Address

INFORMATION TO BE RELEASED

☐ All medical records including mental health treatment, alcohol and drug abuse treatment, HIV/AIDS records., sexually transmitted diseases testing, consultations, secondary records etc.

☐ Partial medical records. Please specify:

- ☐ Office visits
- ☐ FAs
- ☐ Photos
- ☐ Visual Fields
- ☐ Correspondence between Doctors
- ☐ Other: _____

PURPOSE OF RELEASE

- ☐ Moved
- ☐ Changing insurance
- ☐ Changing physicians
- ☐ PCP update
- ☐ Second opinion
- ☐ Other: _____

I understand that I may revoke this authorization at any time prior to the release of information. This authorization expires one year from the date it is signed.

Patient Name	Date of Birth

Signature of Patient, Parent or Legal Guardian	Date