Stewart Family Eye Care

2990 Bliss Cove
Oviedo, FL 32765
P: 407-890-9507 F: 407-890-9509
Email Records to stewartfamiyeye@gmail.com

Authorization for Release of Medical Information

Patient's Name: ______________________________ Date of Birth: ______________________________
Address: ____
Date of Request: ______________________________ Date Needed: ______________________________

OR

☐ I authorize [Company Name] **to release information to**:	☐ I authorize [Company Name] to **obtain information from:**
Name of Provider or Facility	Name of Provider or Facility
Address	Address
City, State, Zip Code	City, State, Zip Code
Phone # / Fax # (include area code)	Phone # / Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one)
☐ Insurance Coverage ☐ Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one)
☐ Entire copy of medical record including last medical and vision insurance information on file.
☐ Specific Information: (Select one or more, as applicable)
☐ Last Examination ☐ Photos ☐ Lab Results ☐ Other
☐ Last examination including last medical and vision insurance information on file.

AUTHORIZATION VALID FOR: (Check one)
☐ One year from the date of this authorization OR ______________ (insert date). This authorization applies to the records of treatment received on or prior to the date of this authorization.

***I understand that*:**
- My right to healthcare treatment is not conditioned under this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.

NOTE: Medical records are faxed to 407-890-9509 or emailed to stewartfamilyeye@gmail.com.

Signature of Patient or Representative: ______________________________ Date: ______________
Relationship to Patient: (*if requester is not the patient*) ______________________________

Office use only:
MR#: ______________________ Date: ______________ Staff Member Sending: ______________________