Authorization for Release of Medical Records

Leigh S Chervenka OD, 163 Amherst St., Nashua, NH 03064, phone (603) 882-9200

Patient Name:_____ DOB:_____

I authorize Leigh S Chervenka OD, to (*please choose only one*)

☐ Send/Disclose information **TO:** ☐Receive information **FROM:**

Name:_____ Phone #:_____

Address:_____ Fax#:_____

Information to be released: (please check or initial)

_____ All records regarding my care at this facility.

_____ Records relating to treatment dates from:_____ to:_____

If my medical records contain information regarding drug/alcohol abuse; physical/sexual abuse; Sexually transmitted disesases including HIV/AIDS; psychiatric/psychological conditions,

I DO_____ I DO NOT_____ authorize the release of that information.

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 insurance coverage and the insurer has the legal 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 send a written notification to Leigh S Chervenka OD. We strive for a prompt turnaround time, but in some circumstances, it may take longer than expected. IF you require records in a certain time frame please, indicate so by noting when you need them.

Date needed_____ We will do our best to meet such a request.

A fax copy or photocopy of this consent shall be as valid as the original.

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records; I may be subject to a fee of $10.00 for the first 10 pages and $1.00 for each additional page. No fee shall be charged for reproducing and forwarding records directly to other physicians.

_____ _____ _____

Patient/Legal guardian signature Date Fee

_____

Printed name and relationship to patient if not patient is signing

*If there is a power of Attorney, or Appointed Guardianship, we do require those documents on file at the office of Dr. Leigh S Chervenka OD prior to any records being released.

This authorization is valid for one year from the date of signature, or until:_____