Authorization for Release of Medical Records

Please Print

Patient's Name _____ **DOB** _____

I request and authorize _____
to release healthcare information of the patient named above to:

Kevin D. O'Neal, M.D., Ph.D.
Cary Eye Center, PLLC.
100 Parkway Office Court
Suite 200
Cary, NC 27518
919-322-1995
fax# 919-827-1321

□Fax Records **□Mail records**

This request and authorization applies to:

□All Healthcare information: (Please send the following now-we will request more only if needed)
□All electronic records (EMA)
□Healthcare information relating to the following treatments, conditions, or dates:
□All Surgery (inside left cover of chart) □Last 4 Office Visits (on paper)
□All Lasik Information □Most recent Visual Fields
□All Cataract Surgery w/Post Op Info (cataract suregery & 3 post-op visits=1 visit)

_____

Signature of Patient/Parent/Guardian or Authorized Prepresentative _____ Date _____

Printed Name of Authorized Prepresentative _____ Relationship _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Cary Eye Center, PLLC. I understand that the revocation will not apply to information that has already been released in repsonse to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise stated, this authorization will expire one (1) year from the date signed.