Keszei Vision Care, PLC

AUTHORIZATION TO RECEIVE / RELEASE MEDICAL RECORDS

Patient Name _____ Date of Birth _____

Address _____ City / State / _____ Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

_____

Name of Person/Organization Releasing Information

_____

Address City / State Zip

_____

Phone Number / / Fax Number

To Release my Information To:

Keszei Vision Care, PLC

Name of Person/Organization Receiving Information

3050 Old Centre Road Suite 102 Portage, Michigan 49024

Address City / State / Zip

(269) 459-8900 (269) 888-2494

Phone Number / / Fax Number

INFORMATION TO BE RELEASED:

Complete Medical Record

Medical Records for Specific Dates of Service (please list) from _____ to _____

Other (please list) _____

This authorization remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X _____ X _____

Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative DATE

_____

Description of Personal Representative's Authority (attach necessary documentation)

Date Sent: _____ By: _____ Via: _____