

# REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_ PHONE \_\_\_\_\_

PATIENT

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

I HEREBY AUTHORIZE: **LEWYCKYJ TAGLIA FELTON EYE CLINIC, 701 SUPERIOR AVE STE A  
MUNSTER, IN 46321 PHONE: 219-934-0150 FAX: 219-934-0152**

TO RELEASE TO: NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
FAX \_\_\_\_\_

A. Only those medical records and correspondence minimally necessary INCLUDING all records regarding mental health/drug, alcohol treatment and/or HIV, AIDS, or communicable disease information.

OR

B. The following specific portions or dates of service of my medical record

- |                         |                       |                       |
|-------------------------|-----------------------|-----------------------|
| 1. History and Physical | 4. Outpatient therapy | 7. Other test results |
| 2. Discharge Summary    | 5. Emergency room     | Kinds: _____          |
| 3. Operative Report     | 6. Laboratory tests   | _____                 |

OTHER: \_\_\_\_\_

FROM DATE \_\_\_\_\_ TO DATE \_\_\_\_\_

FOR THE PURPOSE OF    a) Self                      b) Attorney                      c) Other  
                                    d) Continued Care            e) Insurance

I understand that the information in my health record may include information relating to mental health/drug, alcohol treatment and/or HIV, AIDS, or communicable disease.

It is understood that this authorization is subject to written revocation by me at anytime except for information that has already been released in response to this authorization. This authorization shall remain valid until revoked and will expire in 60 days or upon the following event or condition: \_\_\_\_\_.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 42 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
SIGNATURE OF OTHER AUTHORIZED PERSON\*\*

\_\_\_\_\_  
DATE

\_\_\_\_\_  
RELATIONSHIP OF AUTHORIZED PERSON\*\*

\*\*The signature of a parent (including a non-custodial parent provided there are no court-ordered restrictions) or legal guardian is required for any unemancipated patient under the age of 18. A parent, guardian, or custodian may sign for an incompetent patient. The personal representative of the estate may sign for a deceased patient; if no personal representative, the spouse may sign for a deceased patient; if no spouse or personal representative, an adult child may sign for a deceased patient.