*Medical Records 092019*

# Medical Records Release Form - Patient Request

*TEA_HIPAA_P101_001_A*

Account Number: _______________

**Patient Information**

| Patient Last Name | First Name | Middle Name | Maiden Name |
|---|---|---|---|
| Address (Street or Box) | | City | State / Zip Code |
| Home Phone Number | Cell Phone Number | Date of Birth | |

**Information Requested**

☐ Chart Notes
☐ Dictation
☐ Complete Medical Records
☐ Records from ____________ to ____________
DATE DATE

**Exclusions**

☐ Alcohol / Drug
☐ Behavior / Mental Health / Psychiatric
☐ Sexually Transmitted Diseases
☐ HIV / AIDS
☐ Other (Please Specify) ______________________
☐ No Exclusions

**Exclusions do not apply to Treatment, Payment, or Health care operations.*

**Request Purpose**

☐ Continuing Medical Care ☐ Disability Determination ☐ Worker's Comp
☐ Insurance Claim ☐ Application for Insurance ☐ Legal
☐ Other (Please Specify) ________________________________________________

**RELEASE TO**

| Name | | |
|---|---|---|
| Phone | Fax | |
| Address | | |
| City | State | Zip Code |

**REALEASE FROM**

| Name | | |
|---|---|---|
| Phone | Fax | |
| Address | | |
| City | State | Zip Code |

**Restrictions & Revocations**

This authorization is limited to the following time-period:

This authorization is limited to the following treatment:

Unless revoked, this authorization will be valid for six (6) months from the date of my signature below. To revoke this authorization, I must submit, in writing, to Associated Retinal Consultants, LLC, Attn: Medical Records, 1000 Galloping Hill Road, Suite 305, Union, NJ 07083, or to the site where I submitted the Authorization.

**Re-disclosure:** I understand the information disclosed by this authorization may be subject to re-disclosure by the recipients and no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I release Associated Retinal Consultants, LLC ("ARC") dba Tenafly Eye Associates, an Affiliate of PRISM Vision Group, its employees, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

**Disclaimer:** ARC will make every effort to include all requested information and records, but information may be inadvertently excluded on occasion. We apologize for any accidental omissions. If you are aware of any omission, please bring it to our attention.

**Service Charge:** I understand that, as a courtesy to patients, ARC offers one set of copies free of charge during the service period. If I request more than one set of copies of any or all of my records, during any 12-month period, I may be charged $1.00 per page, not to exceed $100.00, for each set of records that have previously been provided during that time.
(§ 13:35-6.5(c)4)

______________________________________________ ____________________
Patient Signature Date

______________________________________________ ____________________
Legal Representative Printed AND Signature (if applicable) Relationship to Patient

**FOR ARC USE ONLY**

Identity of Requestor verified via: ☐Photo ID ☐ Matching Signature ☐ Other (Specify) ____________________
Records sent by (Print Employee Name) _______________________________ on (Date) _____________
Method of Release: ☐ Self Pick-Up ☐ UPS / FEDEX (Circle One) ☐ Secure Fax