MEDICAL EYE
SPECIALISTS

AUTHORIZATION TO RELEASE PROTECTED INFORMATION

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Bozeman, MT 59718
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406-587-1245

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medeyemt.com

Staff Use Only	☐ Received	Date:	Initials:
	☐ Processed/Faxed/Mailed	Date:	Initials:
			☐ **SCAN ONLY**

1. Patient Information:

Patient Name (First, Middle, Last):	Date of Birth (mm-dd-yyyy):	Daytime Phone:
Patient Address (Street, City, State, Zip):		

2. Release Purpose:

Check appropriate box or write in other purpose.

☐ **Transfer of Care** ☐ **Referral** ☐ **Personal Records** ☐ **Legal** ☐ **Insurance**

☐ **Other, specify**: _____

3. Release Information FROM:

Check one box and complete if applicable.

☐ **Medical Eye Specialists**

☐ **Other**, specify organization, department, or individual (complete each line below)

_____

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

4. Release/Send Information TO:

Check one box and complete if applicable.

☐ **Medical Eye Specialists**
300 North Willson Avenue, Ste. 1003
Bozeman, MT 59715-3551
Fax: (406) 587-1092

☐ **Other**, specify organization, department, or individual (complete each line below)

_____

Street: _____

City: _____

State: _____ Zip: _____

Phone: _____

Fax: _____

This authorization will expire in 1 year from date of signature unless another date is specified: _____

☐ **By checking this box** I allow the ongoing exchange of information between the above parties until this authorization expires or is revoked.

☐ **By checking this box** I also authorize the release for future visits after the date of my signature until this authorization expires or is revoked.

5. Records to Be Released:

Timeframe to Be Released

Date(s): _____ or Year(s): _____

(mm-dd-yyyy) (mm-dd-yyyy)

Document/Note(s) (check all that apply)

☐ Medical Records ☐ Radiology Reports ☐ Operative Reports ☐ H&P Reports

☐ Laboratory Reports ☐ Photos & Visual Fields ☐ Other: _____

6. Delivery Options:

☐ **Mail** ☐ **Pick-Up** ☐ **Fax (Healthcare Facilities Only)**

7. Signature and Date: The patient or legal representative must sign and date this authorization.

I hereby consent to the release of any and all records containing Alcohol/Drug Abuse/HIV/Psychiatric diagnoses under the same consideration as above. I understand that such information cannot be released without my specific consent, except under a Court Order. It is my intent that information released is prohibited for any other purpose than that which is stated above.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Signature: (required)	**Date:** (required) (mm-dd-yyyy)
▶	

Printed Name of Person signing: **(if not patient)** (First, Middle, Last)

Relationship if Not Patient: (legal documentation of the right of access by the signing individual may be required)

☐ Parent ☐ Stepparent ☐ Legal Guardian ☐ Foster parent ☐ Power of attorney/agent ☐ Other: _____