BLOOM FAMILY EYE SURGEONS

ONE CHILDRENS PLAZA

DAYTON, OHIO 45404

Phone 937-723-7772 Fax 937-226-9605

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION

Patient Name: _____Birth Date: _____

Any names patient may have gone by prior to current date: _____

Patient Address: _____

Patient Phone Number: _____

Specific Dates of Treatment Requested: _____

Or

☐ All Records

Release Records To

Name: _____

Address: _____

Phone Number: _____Fax Number: _____

Send Records From

Name: _____

Address: _____

Phone Number: _____Fax Number: _____

I hereby consent to the disclosure of the treatment records to the purpose and extent stated above. The consent will expire 180 days after the date below, or sooner by my choice, in which case this consent will expire on_____. This authorization may be revoked at any time to the extent that disclosure has not already occurred prior to your request for revocation. In order to revoke the authorization the individual/parent/legal guardian who authorized the initial release must do so in writing.

Signature: _____Date: _____

Relationship to Patient_____

*Did You Know: The Health Insurance Portability and Accountability Act (HIPPA) allows healthcare providers 30 days to process record requests with an acceptable extension period of 30 days when required. Bloom Family Eye Surgeons, however, strives to provide records in a timely manner. Did You Know: Requests for information signed by someone other than the patients parent must to accompany by guardianship documentation sighed by a Judge or Magistrate. Did You Know: There may be a charge for your records which will be required before they are released, if you have question regarding a charge for records, please contact our office