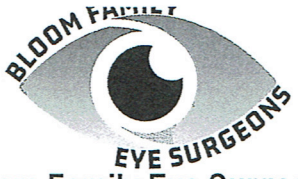

Bloom Family Eye Surgeons
1020 Woodman Drive, Suite 105, Dayton, Ohio 45432
Telephone: (937) 723-7772 Fax: (937) 226-9605

Authorization For Release of Information

Patient Information

Patient Name: _____ Birth Date: _____

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

Patient Address: _____

☐ Specific Dates of Treatment Requested: _____

☐ Last Office Note ☐ All Records

Release Records To

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____ Attention to: _____

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 the 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 30days 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 patient's parent must be accompanied by guardianship documentation signed by a Judge or Magistrate.
* I understand there will be a fee if records are not sent from physician to physician