



An affiliate of PRISM Vision Group®

Account Number: _____

Medical Records Release Form - Patient Request

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

RELEASE 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: _____

I understand that I have the right to revoke this authorization in writing. For exceptions to your right to revoke this authorization, please refer to our practice's Notice of Privacy Practices. Unless revoked, this authorization will be valid for one (1) year from the date of my signature below. To revoke this authorization, I must submit, in writing, to Associated Retinal Consultants, LLC, Attn: Medical Records, 420 Mountain Avenue, 4th Floor, New Providence, NJ 07974, or to the site where I submitted the Authorization. I understand that the practice may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this 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"), 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 a fee according to applicable state law.

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