Reset From

John C. Hersey, OD

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www.HerseyEyeCare.com

Authorization to Release Health Care Information

Patient Name: _____ **D.O.B:** _____

Hereby Authorizes: _____

_____

_____

_____

To disclose my health care information to: _____

_____

_____

_____

I understand that originals of all records generated while I was a patient of this practice will be kept and, upon request, I will be provided a copy of them. I also understand to insure confidentiality that I may be asked to show identification, including a picture, such as a driver's license. I realize this is for my protection and to help insure my confidentiality. Further, I understand that I may be asked to pay a reasonable that I may be asked to pay a reasonable charge for copying my records and that this amount must be paid prior to the records being released.

The reason I am requesting these records is:

_____ Transfer of Care

_____ For a Consultant/Specialist Appointment

_____ Personal Records

_____ Other: _____

_____

Patients Name (Print)**:** _____ **Date:** _____

Patients Signature: _____ (Parent, if minor)

Witness: _____