Makar Eyecare

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Records Release Authorization

This authorization must be signed and dated by the person authorized by law to grant this permission.

Patient Name_____

Date of Birth_____/_____/_____

Please send records for the above named patient **to** Makar Eyecare, LLC from:

☐ Provider/Office: _____

Address: _____

_____

Phone: _____

Fax: _____

OR

Please send records for the above named patient **from** Makar Eyecare, LLC to:

☐ Provider/Office: _____

Address: _____

_____

Phone: _____

Fax: _____

This authorization is for: ☐ All Medical Records

☐ Specific Information: _____

I hereby give my authorization to release a copy of my medical records, reports or test results related to care of myself (or the person named above, for which I have authority to sign for). I understand that this consent expires one year after the date signed below or that I may revoke this authorization in writing sooner if I choose by presenting the provider with a written notice of revocation. If revoked, no actions already taken based upon this authorization will be affected. Information may be re-disclosed if the recipient named on this form is not required by law to protect the privacy information. In such a case, the disclosed information will no longer be affected by federal health information privacy regulations.

_____ _____/____/_____

Signature of person authorizing release — Today's Date

_____ _____

Printed name of person (if other than the patient) — Relationship to patient

Please Note : The information contained in this communication is confidential and intended only for the designated recipient. If you received this communication in error, you are hereby notified that review, dissemination, distribution or copying of this information is forbidden. If you are not the intended recipient, please notify our office immediately by telephone or fax.