Strom
Eye Center

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

I authorize _____

(Name of Facility/Person)

_____

(Facility/Person Address)

to release information from the record of:_____,_____

(Patient Name) (Date of Birth)

To: Strom Eye Center
2020 S Tamiami Trl
Sarasota, Florida 34239
(941) 365-9700, Fax: (941)-365-9717

The specific information that I wish to have released is:

☐ All Clinical Medical Records

☐ Other Records- Please list (e.g. billing, visual fields, etc.):

_____

_____

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

I understand that this authorization is valid for a 90 day period from the date that it is signed, unless otherwise specified below. I understand that I have the right to revoke this authorization at any time by sending a written request to the facility/person I authorized to release the information. If applicable, specify other expiration date here: _____

Signature: **Date:**

(Patient, Parent or Legal Guardian)

_____

(Printed name if not signed by Patient) (Relationship/Authority to Act on behalf of the patient)