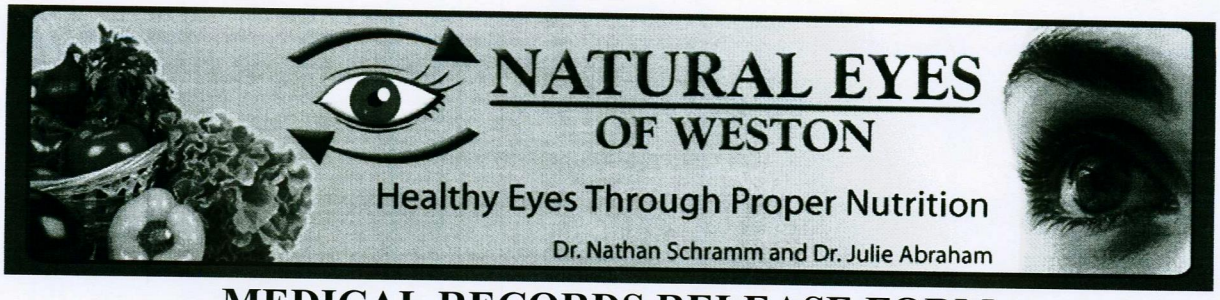

MEDICAL RECORDS RELEASE FORM

Request Date:_____

Patient Name:_____ DOB:_____

Additional Patient Name:_____ DOB:_____

Additional Patient Name:_____ DOB:_____

Additional Patient Name:_____ DOB:_____

Patient Address:_____

_____

I hereby authorize the one-time release of my protected health information **TO** (mark one):

___ Natural Eyes of Weston
2863 Executive Park Dr.
Ste 103 Weston, FL 33331
TEL: 954-217-2992
FAX: 954-217-2245

___ _____

_____

_____

via: IN-PERSON MAIL FAX EMAIL
(circle one)

Disclosures regarding records released **FROM** Natural Eyes of Weston:

1. Medical records will be released within thirty (30) business days.
    a. Records from other providers will not be released and may be obtained directly from that provider.
    b. Insurance explanations of benefits are available directly from your insurance company.
    c. Color documents,such as photographs and color printouts will only be released via email.
2. Records FAXED/EMAILED directly to another provider may be released free of charge as a professional courtesy.
3. All other record releases will have a fee of $8.00 for the first patient and $5.00 for each additional.
4. Records required to be released the same day will be assessed an additional $10.00 handling fee for each patient.
5. Records will not be released until payment is received.
6. Individual written consent will be required for each adult listed above.
7. Records may contain sensitive information, including information related to diseases you may have.

Patient Signature:_____
(Parent or Guardian signature if patient is a minor)

Printed Name:_____