INLAND EYE CARE
212 Rodeo Drive, Suite 410 Moscow, ID 83843
(p) 208-874-0020 (f) 208-874-0019
admin@inlandeyecare.com

Authorization for Release of Medical Information

Patient's Name: _____ Date of Birth: _____
Address: _____
Date of Request: _____ Date Needed: _____

OR

☐ I authorize Inland Eye Care **to release information to**:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

☐ I authorize Inland Eye Care to **obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

PURPOSE FOR THIS REQUEST: (Check one)
☐ Insurance Coverage ☐ Transfer of Care ☐ Other

TYPE OF RECORDS REQUESTED: (Check one)
☐ Entire copy of medical record including last medical and vision insurance information on file.
☐ Specific Information: (Select one or more, as applicable)
☐ Last Examination ☐ Photos ☐ Lab Results ☐ Other
☐ Last examination including last medical and vision insurance information on file.

AUTHORIZATION VALID FOR: (Check one)
☐ One year from the date of this authorization OR _____ (insert date). This authorization applies to the records of treatment received on or prior to the date of this authorization.

***I understand that*:**

- My right to healthcare treatment is not conditioned under this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.

NOTE: Medical records are faxed to 208-874-0019 or emailed to admin@inlandeyecare.com

Signature of Patient or Representative: _____ Date: _____
Relationship to Patient: (*if requester is not the patient*) _____

Office use only:
MR#: _____ Date: _____ Staff Member Sending: _____