TREASURE VALLEY | EYE CENTER

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH:**_____

ADDRESS:_____ **PHONE NUMBER:**_____

_____

This is to authorize that medical information regarding the above person be released:

TO/FROM:

Mark R. Miller, MD

Bret D. Williams, OD • Rob D. Christensen, OD

3045 E. St. Luke's Street Suite #100 Phone: (208) 288-2020

Meridian, ID 83642 Fax: (208) 288-2015

TO/FROM:_____

_____

_____

PURPOSE OR NEED FOR RECORDS:_____

COPIES OF RECORDS REQUESTED:

FROM DATE:_____TO DATE:_____

(Check all that apply)

_____CURRENT RECORDS

_____PROGRESS NOTES

_____LAB REPORTS

_____X-RAY REPORTS

_____HOSPITAL RECORDS

_____OTHER_____

I understand that my records may contain information regarding drug or alcohol abuse, mental illness, psychiatric treatment, and/or sexually transmitted diseases, including HIV (AIDS) information. I give my specific authorization for these records to be released.

This authorization is valid for six months unless revoked in writing earlier. Any redisclosure of information obtained by this authorization is prohibited except with the written consent of the patient.

Signature_____ Date_____