KOVACH EYE
INSTITUTE

Authorization for Release of Medical Records

Name: _____ Date of Birth:_____

Street Address:_____Tel Number: _____

City:_____State: _____Zip Code:_____

PLEASE ALLOW A MINIMUM OF 10 WORKING DAYS TO COMPLETE YOUR REQUEST

The specific information that I wish to have released is:
❑ All Clinical Medical Records
❑ Other Records - Please list (e.g. billing, angiograms, photographs, etc.):

Signature: _____ Date: _____
(Parent or Legal Guardian of Minor) *Must be actual signature not E-sign*

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.

Signature: _____ Date: _____
(Parent or Legal Guardian of Minor) *Must be actual signature not E-sign*

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.

Signature: _____ Date: _____
(Parent or Legal Guardian of Minor) *Must be actual signature not E-sign*

I understand that this authorization is valid for a ten (10) day period from the date that is signed. I may revoke this consent at any time through written notice.

Release Records to:

Name: _____ Tel. No.: _____ Fax No: _____

Street Address: _____ Email: _____

City: _____ State: _____ Zip Code: _____

OMIC release 01/09/2003