Medical Records Release Form

Patient Last Name	Patient First Name	MI	
Maiden Name	DOB	Primary Phone	
Address (Street or Box)	City	State	Zip Code

Information Requested:

- ❑ Chart Notes
- ❑ Complete Medical Record
- ❑ Records from __________ to __________

Exclusions:

- ❑ Alcohol/Drug
- ❑ Behavior/Mental Health/Psychiatric
- ❑ Sexually Transmitted Diseases
- ❑ HIV/AIDS
- ❑ Other (Please Specify) ____________________
- ❑ No Exclusions

Release To

Name: ______________________________

Phone: __________________ Fax: ______________

Address: ______________________________

City: ____________________ State: ________

Zip: _______________

Release From

Name: ______________________________

Phone: __________________ Fax: ______________

Address: ______________________________

City: ____________________ State: ________

Zip: _______________

Request Purpose:

- ❑ Continuing Care
- ❑ Disability Determination
- ❑ Application for Insurance
- ❑ Insurance Claim
- ❑ Worker's Comp
- ❑ Legal
- ❑ Other (Please Specify) ____________________

Method of Release:

- ❑ Mail
- ❑ E-mail
- ❑ Fax
- ❑ In-Person Pickup

Patient Signature: ____________________________________ Date: ________________

Legal Representative/Legal Guardian: ______________________ Relationship: ____________

I understand that I have the right to revoke this authorization in writing. For exceptions to your right to revoke this authorization, please refer to our practice's Notice of Private Practices. Unless revoked, this authorization is valid for 1 year from the date of the signature below. To revoke this authorization, please contact McConkey Eye Care. By signing this, you understand that McConkey Eye Care may not condition treatment, payment, enrollment, or eligibility for benefits.

McConkey Eye Care, LLC
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