Boston Eye Group Medical Records Request Form

323 Lowell St Suite 102 Andover, MA 01810 | **1101 Beacon St., Suite 6** Brookline, MA 02446 | **25 Marston St #104** Lawrence, MA 01841 | **92 High St Suite T31** Medford, Ma 02155 | **16 Asylum St** Milford, MA 01747 | **204 Worcester St** Wellesley, MA 02482

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Authorization to Obtain/Release Medical/Psychiatric/Substance Abuse Information

Patient Name:_____ Date of Birth: _____

Patient Address: _____

Telephone:_____ Fax: _____

I hereby authorize: **Boston Eye Group** to release the medical records of the above-named person to the following persons/facility: (Please check one, and fill out additional information).

☐ Myself:
   a. Home address: _____
   b. Email address: _____

☐ Another doctor's office or facility:
   a. Address of facility: _____
   b. Phone number of facility:_____ Fax number of facility: _____

Are you leaving our practice? (check one)
☐ Yes
☐ No
If **YES**, we would appreciate your feedback in order to improve the experience of our current and future patients.

_____

_____

Signature of this document will verify that:

- I understand that treatment and coverage is based upon my signing this authorization. The information is needed for the following purposes: (circle one)
  - To provide ongoing treatment/aftercare.
  - At the request of the patient (or parent, or legal guardian).
  - Other (please specify): _____
- I understand this authorization is subject to revocation at any time unless action based on it has already begun. Requests for revocation will be done in writing. The authorization expires 90 days from the date of signature.
- I understand that the information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I further release the persons and/or agencies named above from any liability arising from the release of this information to such persons and/or agencies, provided the said release of information is done substantially in accordance with applicable law.

Date:_____ Signature of Patient: _____

Signature of parent/legal guardian, if patient is under 18_____ / Relation to patient: _____

Please fill out this section *only* if applicable:
I DO / I DO NOT (circle one) authorize disclosure of information which refers to treatment or diagnosis of drug or substance abuse which I understand is protected by Federal Regulation: 42 CFR Part II.
Date:_____ Signature:_____
I have carefully read and understand the above statement and do herein expressly and voluntarily consent to disclosure of information and/or psychiatric records including Alcohol and Drug Abuse information, if applicable, about my condition and treatment to those persons/agencies named above, provided a release of information is done substantially in accordance with

AUTHORIZATION TO RELEASE H.I.V. INFORMATION

I hereby specifically authorize the release of HIV (HTLVIII) antibody or antigen testing or records containing HIV, HIV virus or any AIDS related conditions, which may be contained in the above referenced request.
Date:_____ Signature: _____

SUBMIT