Consent for release of information

I, _____authorize_____, its authorized employees, or agents to discuss with & disclose my treatment records to Midcoast Eyecare, LLC (Rockland Eyecare.)

Please forward:
___All of my treatment/record information including history, dates, course & summary of treatment & photographs.
___Treatment records on file from other health care practitioners
___Statements I have added to my treatment records with response, if any.

This information may be used for ongoing treatment/aftercare.

___I Do__ I Do Not authorize the release of any information relating to the diagnosis or treatment of Alcoholism, Drug Abuse, Mental Health Treatment, HIV, ARC, or AIDS. If I authorize release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent.

___I Do___I Do Not want to review this information before it is released. I understand that any such review must be supervised.

My consent to release these records is effective for 12 months & I authorize future disclosures regarding these records to the same individuals during this time period.

I understand that:

- I can revoke all or part of this authorization at any time by notifying the person mentioned in the first line in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation.
- I can refuse to disclose all or some of the information in my treatment records.
- A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial or insurance coverage or claim for health benefits, or other adverse consequences.
- I can have a copy of this form upon request.
- I can cross out any provision on this form with which I disagree.

Signed:_____ Date:_____

(Patient or his/her legally appointed representative) Date of Birth:_____