MIDCOAST EYECARE LLC

Patient Name: **DOB:**

Medical Records From:

Rockland Eyecare
1100 Commercial Street
Rockport, ME 04856

Damariscotta Eyecare
590 Main Street
Damariscotta, ME 04543

Medical Records: (circle one) **mailed/faxed to** **picked up by**

Name

Address

City/State/Zip Code

Phone Number

Fax Number

Records Requested:

	Last office visit
	Complete Medical Record (may be subject to charge)
	Other (please specify)

Purpose of Disclosure:

I authorize the release of medical information to another provider/facility as deemed necessary for my treatment. I further authorize *Midcoast Eyecare, LLC* to obtain medical information from another provider/facility as deemed necessary in the course of my treatment. This authorization may be revoked, by me, in writing, at anytime. Information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by HIPAA. My health care and payment for my health care will not be affected by refusing to sign this form. I understand that I may see and copy the information described on this form as requested. **I understand there may be a fee for copying medical records as allowed by federal and state law. I understand that it may take 30 days for medical records to be released and that *Midcoast Eyecare, LLC* may withhold records until the medical record fee is collected.**

Printed Name of Requested **Relationship to patient**

Patient/Parent/Guardian Signature **Date**

Address

Telephone Number

This release expires 1 year from signature date above, unless specified otherwise in writing.