AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Name: ______________________________ Date of Birth: ____________________

hereby authorizes: ____

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to disclose my health care information to:

Eye Center Northeast
Dr. David T. Douglass
Dr. Chloe C. Douglass
Dr. Ian M. Jones
955 Broadway Bangor, Maine 04401
Phone (207) 990-4388 Fax (207) 947-9241

Please send records concerning (initial appropriate lines):

___ Medical problems
___ Psychiatric/Psychological
___ Chemical/Alcohol Dependency
___ AIDS/HIV Testing and Treatment
___ Immediate Records or Last Two years of records

I understand that the originals of all records generated while I was a patient of this practice will be kept and, upon request, I will be provided a copy of them. I also understand to ensure confidentiality that I may be asked to show identification including picture, such as a driver's license. I realize this is for my protection and to help ensure my confidentiality. Further, I understand that I may be asked to pay a reasonable charge for copying my records and that this amount must be paid before the records will be released.

The reason I am requesting these records is:

___ Transfer of care
___ For consultation or specialist appointment
___ Personal records
___ Other

I have carefully read this form, and I wish to have the designated medical information released. I will not hold the above name responsible for any misuse of this information which may occur. I further understand that this release remains in effect for all subsequent disclosures as above for 30 months unless I present a written, signed, and dated revocation prior to the expiration date. A copy of this disclosure will be provided upon request.

Patient Name (print) ______________________________ Date ______________

Patient Signature (parent if minor) ________________________________