AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name:_____ Date of Birth: _____

I authorize:

VisionPoint Eye Center
1107 Airport Road
Bloomington, IL 61704
visionpointeye.com
p#309-662-7700
f#309-662-0829

***to release my records to** **<<< (circle one) >>>** ***receive my records from**

Name _____

Address_____

Phone#_____

Fax# _____

Reason for release

__ Personal copy __ Continuity of Care __ Moving __ Disability

__ Transferring Care __ Insurance __ Other _____

_____ **X_____**
Date **Patient/ Legal Guardian Signature**

_____ **X_____**
Date **Witness Signature**

****I understand that I may revoke this consent at anytime with the exception of records that have already been released and that any records received from another provider will not be released. Records are normally ready in seven to ten business days. Please fill out this form completely. Any items left blank will delay the release of your records. This message is intended for the use of the person or entity to which it is addressed and may contain information that is confidential, the disclosure of which is governed by applicable law.***