Patient Authorization for Release of Medical Records

Central Kentucky Eyecare
3221 Summit Square Pl #200
Lexington, KY 40509
Ph: 859.303.6464 F: 859.303.6465

Patient Name:_____ Date of Birth:_____

Phone number:_____

I hereby authorize all medical records including imaging and other tests be released (Choose 1):

☐ TO Central Kentucky Eyecare FROM: Office Name:_____
Address:_____

☐ FROM Central Kentucky Eyecare TO: Office Name:_____
Address:_____

Please check the item(s) you would like to have sent or received:

____ ALL records including images and tests ____Test results and reports only

____Contact lens prescription only ____Glasses prescription only

A. I understand that ONLY records/information requested will be released to the specified entity. Additional information requested to be SENT to another provider will require another signed release or verbal request by the patient and/or legal guardian if the patient is a minor.
B. *I understand that per HIPAA:*
    a. *A copy of my health information as indicated above, is to be provided to Central Kentucky Eyecare within 30 days of my request. A provider cannot deny me a copy of my records because I have not paid for health services I have received.*
    b. *Central Kentucky Eyecare has up to 30 days to release my records to the entity indicated above.*

Patient Signature (legal guardian if minor):_____

Date:_____