

**Kennebec Eye Care, P.A.**

**Authorization To Release Health Care Information**

Where records are now:  
(Dr.) \_\_\_\_\_  
(Practice) \_\_\_\_\_  
(Street) \_\_\_\_\_  
(City/Town) \_\_\_\_\_  
(State) \_\_\_\_\_ (Zip) \_\_\_\_\_

To receive records:  
(Dr.) \_\_\_\_\_  
(Practice) \_\_\_\_\_  
(Street) \_\_\_\_\_  
(City/Town) \_\_\_\_\_  
(State) \_\_\_\_\_ (Zip) \_\_\_\_\_

I, \_\_\_\_\_ give \_\_\_\_\_, its authorized employees and  
(Patient name/representative) (Doctor/facility)  
agents permission to disclose the health care information described below relating to \_\_\_\_\_

Purpose of request:

- \_\_\_\_\_ To provide ongoing treatment and care.
- \_\_\_\_\_ To coordinate treatment efforts with other physicians, family members, and others.
- \_\_\_\_\_ Other: \_\_\_\_\_

Information to release:

- 1. \_\_\_\_\_ All information including history, dates, course and outcome of treatment.  
**NOTE:** I understand that my record may contain information related to drug and/or alcohol use, psychiatric treatment, sexually transmitted disease, HIV treatment or other sensitive information.

2. Release only the following information:

\_\_\_\_\_ Physician Office Records                      \_\_\_\_\_ Hospital Records (in/outpatient)  
\_\_\_\_\_ Other Treatment records                      \_\_\_\_\_ Test Results  
\_\_\_\_\_ Statements I have added

Information I Refuse to release: \_\_\_\_\_

**NOTE:** I can refuse to disclose some of my records. Partial or incomplete records will be labeled as such to inform the provider receiving them of their status.

I can revoke my consent at any time prior to the release of records by delivering a written, signed and dated notice of my wishes to ***Kennebec Eye Care, P.A.***

A decision to withdraw my consent to release records or refusal to disclose some of my records, however, may result in an improper diagnosis or treatment, denial of health benefits or insurance coverage or benefits or other adverse consequences.

PATIENT INITIALS \_\_\_\_\_

My consent to release my records is effective until \_\_\_\_\_. (Date not to exceed 30 months from consent).

I do \_\_\_\_\_ I do not \_\_\_\_\_ authorize re-release of the information. (A copy of this form is available to signer upon request.)

\_\_\_\_\_  
(Signature of patient or legal rep)                      (Relationship to patient)                      (Date)

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ SSAN: \_\_\_\_\_

Street \_\_\_\_\_ City/Town \_\_\_\_\_ Zip \_\_\_\_\_