Port Royal Eye Care

Dr. Stephanie Price, OD
4886 Port Royal Road Suite 150 Spring Hill, TN 37174
Phone: 931-489-6118 / Fax: 931-623-6108

Medical Release Form:

Patient's Name:_____ Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Phone: _____

I hereby authorize the release of my medical records TO: __ Myself

__ Port Royal Eye Care/ Dr. Stephanie Price, OD Fax: 931-623-6108

4886 Port Royal Rd Suite 150 Phone: 931-489-6118

Spring Hill, TN 37174

FROM:

__ Office/Physician:_____ Fax:_____

Address: _____ Phone:_____

City: _____State:_____Zip:_____

Note: Please include: __ Last glasses/contact Rx

__ Last exam including testing and clinical notes __ Last 3 exams including testing and clinical notes

__ Entire record including consult letters, referral letters, clinical testing (VF, Photos, OCT, etc.)

*I understand that I will be charged the State of TN Records Access Act Fees, plus postage to copy these records. I also understand this release is effective for six months from today and I may revoke my consent at any time by written consent. (The revocation must be legible and include the name, date of birth, and date of revocation.)

*I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility of benefits.

*Unless otherwise revoked in writing, this authorization will expire ONE YEAR from the signature date below or on the following date, event, or condition:

I,_____, certify that I am the patient or legal guardian with the authority to authorize disclosure of this individual's protected health information.

_____ _____ _____

Signature of patient/legal guardian *Relation to patient/legal authority* *Date*