Medical Records

Patient Name____Date______________

I authorize Gleneagle Vision Center, P.C. to release my medical records **to**:

Name: ____

Address: ____

Phone #: _________________________________Fax #: _____________________________

I authorize Gleneagle Vision Center, P.C. to request my medical records **from**:

Name: ____

Address: ____

Phone #: _________________________________Fax #: _____________________________

Please include (circle):

ALL RECORDS Last 3 visits Prescriptions Testing Other__________________

I understand that I am allowing Gleneagle Vision Center, P.C. to release or request my personal medical records following all privacy and HIPAA guidelines and this information is not to be shared with other entities unless written authorization is given.

I understand that I may revoke this consent at any time in writing. I further understand that this consent will automatically expire after one year if I do not revoke this consent before that period.

No other information will be forwarded to other persons or agencies without my express consent.

____

Patient Name Date

____

Patient/Guardian Signature

15435 Gleneagle Dr., Suite 110 | Colorado Springs, CO 80921

Phone: 719.884.8480 | Fax: 719.884.8483