

Virginia Pediatric Eye Center

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Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Telephone #: _____

I hereby agree and **authorize** _____ to disclose protected health information to:
Health Care Facility or Physician Name

Health Care Facility or Physician Name

Telephone # _____ Fax # _____

Purpose of Request:

Continued Care Personal Attorney/Legal Insurance Disability Other: _____

Records Requested:

Physician/Office Notes Operative/Surgical Notes Other (be specific): _____

I understand that I may revoke this authorization at any time by giving written notice except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and send it to Earl R. Crouch, Jr., M.D., F.A.C.S., P.C.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the federal Privacy Standards.

This authorization expires _____

Print Name of Patient: _____ Patient's Date of Birth: _____

Signature of Parent or Personal Representative:* _____ Date: _____

Print Name Parent or Personal Representative:* _____

* If an authorization is signed by an individual's Personal Representative, the representative's authority is based on: _____ (e.g. state law, court order, etc.)

As deemed legal by the Commonwealth of Virginia, charges for copies of medical records are as follows:
\$10 handling fee plus \$0.50 per page (1-50 pages) plus \$0.25 per page (over 50 pages).