LEXINGTON EYE ASSOCIATES INC.

Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone (H) _____ (C) _____

Release Records: ☐ To: _____ ☐ From: _____

Name (or Facility): _____ Attn: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone _____

If you do not want your entire medical record to be released, specify here what information should be released (e.g. specific dates of service): _____

I would like this information: ☐ Faxed ☐ Mailed ☐ Convert to CD ☐ Pick Up Records at the _____ Office

NOTE: There is a charge for Lexington Eye Associates to copy your medical record, in accordance with Massachusetts law (MGL Chapter 111,Section 70). There is a base cost of $10, for the first 1 – 10 pages. Each additional page will be $.50 per page.

I hereby authorize Lexington Eye Associates to Release/Obtain all information in my medical record including the treatment of the following issues if applicable to me:

___ Abortion
___ Alcohol or Drug Abuse
___ Domestic Violence
___ Genetic Testing and Results
__ Mental Health Counseling
__ Sexual Assault
__ Sexually Transmitted Diseases
__ AIDS/ARC and or HIV testing and results

SIGNATURE REQUIRED _____

I understand that this authorization will remain in effect for 90 days, or I will provide a written notice of revocation to Lexington Eye Associates. The revocation will be effective immediately upon receipt of my written notice, except the revocation will not have any effect on any action taken by Lexington Eye before the written notice of revocation is received. I understand that the federal privacy law may no longer protect the information furnished after it is released. I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason, and that such a refusal or revocation will not affect the commencement, continuation, or quality of treatment by Lexington Eye. I hereby release Lexington Eye Associates, Inc from all legal responsibility or liability that may arise from the release of this information or re-disclosure by the recipient(s). This authorization will remain in effect for 90 days or until_____.

Date: _____ Signature of Patient or Representative: _____

If signed by a personal representative, please describe authority or relationship: _____