LEXINGTON EYE ASSOCIATES INC

781-876-2020
WWW.LEXEYE.COM

Patient Name: ____ Date of Birth: _________________________

Address: ____________________________________ City: _____________ State __________ Zip _____________

Phone (H) ______________________ (C) ______________________ (Other) ______________________________

I am requesting my records to be released because: ____

Release Records To: Facility/Physician______________________ ☐ Family Member Name _________________ ☐ Self

Address: ____ City: ____

State: __________ Zip: __________ Phone ______________Fax:________________ Date Records Needed:__________

Obtain Records From: Name of Facility/Physician ____

Address: ____ City: __________________________________

State: __________ Zip: __________ Phone ______________Fax:________________ Date Records Needed:__________

I would like this information: ☐ Faxed ☐ Mailed ☐ Pick up in office

Please select office:

- ☐ **Lexington** – 21 Worthen Road, Lexington, MA 02421 **FAX** - 781-863-9416
- ☐ **Concord** – 300 Baker Avenue - Suite 210, Concord, MA 01742 **FAX** - 978-369-4738
- ☐ **Westford** – 160 Littleton Road – Unit 9, Westford, MA 01886 **FAX** - 978-589-9921
- ☐ **Arlington** – 1040 Massachusetts Avenue, Arlington, MA 02476 **FAX** - 781-648-6524
- ☐ **Sudbury** – 534 Boston Post Road. Sudbury, MA 01776 **FAX** - 781-209-5059

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. Records will be sent to the designated address within 30 days of request.

I hereby authorize Lexington Eye Associates to Release or Obtain 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 1 year, 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 1 year, or until the following date: ___________________.

Date: __________________ **Signature of Patient or Representative:** ______________________________________

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