Ophthalmology Consultants of Fort Wayne, P.C.

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RELEASE OF MEDICAL RECORDS

Date: _____

Patient Name: _____
(Last) (Name) (Middle Initial)

Patient Address _____

City _____ State:_____ Zip _____

Patient's Date of Birth: _____

I hereby authorize **OPHTHALMOLOGY CONSULTANTS OF FORT WAYNE, P.C.** to release all information concerning the medical history, examinations, treatments, hospitalization and/or surgery for the above listed patient to:

Name: _____

Address _____

City _____ State:_____ Zip _____

FOR THE PURPOSE OF _____

Ophthalmology Consultants of Fort Wayne, P.C. has thirty (30) days from the date of this request, to make available to me my personal health information. If my personal health information is maintained off-site, Ophthalmology Consultants of Fort Wayne, P.C. has sixty (60) days, from the date this request is received, to make available my personal health information.

I understand that if I am requesting a copy of my personal health information that there is a fee imposed. Payment is due in its entirety, prior to my records being released. I further understand that there is no charge to have my records released to a physician.

Signed _____ Date _____
(Parent, Guardian or Designated Healthcare Representative, if applicable)

For Ophthalmology Consultants of Fort Wayne,P.C. use only . . .

Action Taken _____

Date: _____ By _____