Whiting Clinic

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____ Phone Number: _____

I authorize Whiting Clinic (the "Company") to release the following information from my medical record:

__ Complete Treatment Record without limitation

__ Treatment Record of the following Date(s) _____

__ Billing and payment records

__ Other (describe): _____

I authorize the following person(s) or organization to receive the information:

Name: _____

Address: _____

I prefer the records be faxed to: _____

I prefer the records be emailed to: _____

This authorization will expire in 90 days after the date below, or sooner by choice, in which case this authorization will expire on _____, except to the extent action has already been taken in reliance upon this authorization.

I authorize the release of any information contained in my treatment records that might contain sensitive information including information concerning diagnosis and/or treatment of alcohol or substance abuse, drug related conditions, mental health conditions, developmental disabilities, sexually transmitted diseases, communicable diseases, genetic testing and/or HIV/AIDS related conditions.

I understand that treatment information released pursuant to this authorization could be subject to redisclosure by the recipient and my no longer be protected by federal law. If the information released under this consent includes alcohol or drug treatment records, the person(s) receiving this information are hereby notified that federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

I understand that my refusal to sign this authorization will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. I understand that I may revoke this authorization at any time by notifying, in writing, the Medical Records Custodian (address listed below). I further understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that the Company and its workforce are released from legal responsibility or liability for disclosing protected health information authorized by my signature below. The Company reserves the right to send the record to the physical mailing address of the recipient if the medical record is too large to send/receive by email or fax.

_____ _____

Printed name of patient Date

_____

Signature

You may send your completed authorization to RecordsRequest@Lasik.com , by fax to (513) 672-9749 or by regular mail to Medical Records Custodian, 7840 Montgomery Rd., Cincinnati, OH 45236

Note: Please allow 30 days for fulfillment or transfer of your medical records request. This is a general estimate and could require more or less time depending on several factors like when you had your procedure. If your medical records are needed for an important appointment or procedure with another doctor's office, please plan with the fulfillment period in mind. To ensure we protect your patient information there is not a way to expedite the records fulfillment process. Records are only kept for 10 years before they are destroyed.