CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the Cape Fear Eye Associates, PA, or any of its employees, staff, or agents, to use and disclose health information from the medical record(s) of:

Patient Name: _____ Phone Number: _____

Address: _____
(Street) (City) (State) (ZIP Code)

Date of Birth: _____ Medical Records #: _____

Release information to: **(Please check appropriate box below)**

□ Cape Fear Eye Associates, PA, 1726 Metro Medical Drive Fayetteville, NC 28304 Fax (910) 484-1673

Requesting records from: _____

Office # _____ Fax # _____

□ _____
(Name of individual or organization) (Street), (City, State, Zip) (Phone Number) (Fax Number

_____ Patient Pick-up

Initial all that apply:

I am requesting the following information to be released:

_____ Abstraction of record (includes: Operative reports, consultations, laboratory findings, and other significant findings)

Date(s) of Treatment: _____

_____ Entire medical record

75 cents per page for first 25 pages
50 cents per page for pages 26-100
25 cents per page for each page in excess of 100

I permit this confidential information to be released for the following purpose:

_____ Continuing medical treatment released to physician (name) _____

_____ Litigation for review (name of Legal firm) _____

_____ Personal release

_____ Insurance (company name): _____

_____ Other: Specify Reason: _____

This consent permits Cape Fear Eye Associates, PA to use and disclose my health information to carry out treatment, payment, or health care operations. Additional information regarding the uses and disclosures of health information is described in the Cape Fear Eye Associates, PA notice of privacy Cape Fear Eye Associates, PA. A patient has the right to review the "notice" prior to signing this consent. A patient has the right to request restrictions, uses, and disclosures of health information for treatment, payment, and health care operations purposes. However, the Cape Fear Eye Associates, PA are not required to agree to a patient's request for restrictions. I may revoke this consent to release confidential information in writing, at any time, except to the extent that action has already been taken. No further confidential information is released without the execution of an additional written statement of authorization. I understand that these records are protected under federal and state law and cannot be disclosed without my consent unless otherwise provided by law. Having read the above information, I hereby RELEASE, HOLD HARMLESS, AND AGREE NOT TO SUE Cape Fear Eye Associates, PA, its employees, staff, and agents, in connection with the disclosure of information set forth relating to these medical records.

_____ (Print Patient's Name)

_____ (Signature of Patient) Date: _____

_____ (Signature of Legally Authorized Person)

**I am aware that there are potential fees for release of medical records, etc. A request may take up to 30 working days to process and if needed, can be extended to 60 days. If you do not receive the records within 30 days, you should call Medical Records Department at 910-484-2284 ext 260.