

Ascent Eye Care & Eyewear Gallery

1441 New Highway 96 W, Ste 3
Franklin, TN 37064
Phone 615-560-8245 Fax 615-560-8249
Email Records to drtboone@ascenteyecare.com

Authorization for Release of Medical Information

Patient's Name: _____	Date of Birth: _____
Address: _____	
Date of Request: _____	Date Needed: _____

OR

<input type="checkbox"/> I authorize [Company Name] to release information to: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone # / Fax # (include area code)	<input type="checkbox"/> I authorize [Company Name] to obtain information from: _____ Name of Provider or Facility _____ Address _____ City, State, Zip Code _____ Phone # / Fax # (include area code)
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PURPOSE FOR THIS REQUEST: (Check one)

Insurance Coverage Transfer of Care

TYPE OF RECORDS REQUESTED: (Check one)

Entire copy of medical record including last medical and vision insurance information on file.
 Specific Information: (Select one or more, as applicable)
 Last Examination Photos Lab Results Other
 Last examination including last medical and vision insurance information on file.

AUTHORIZATION VALID FOR: (Check one)

One year from the date of this authorization OR _____ (insert date). This authorization applies to the records of treatment received on or prior to the date of this authorization.

I understand that:

- My right to healthcare treatment is not conditioned under this authorization.
- I may cancel this authorization at any time by submitting a **written** request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.

NOTE: Medical records are faxed to 615-560-8249 or emailed to drtboone@ascenteyecare.com.

Signature of Patient or Representative: _____ Date: _____
Relationship to Patient: (if requester is not the patient) _____

Office use only:

MR#: _____ Date: _____ Staff Member Sending: _____