LasikPlus®
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Authorization for Release of Medical Information

I, _____ (Print Name of Patient), hereby authorize

Doctor/Facility _____

Address_____

City, State, and Zip Code _____

to release my individual medical information as described below:

_____ 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_____

Street Address _____

City, State, and Zip Code _____

I authorize the release of any information contained in my treatment records that might include information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological condition and/or psychiatric/mental health treatment and/or HIV related conditions.

_____ (Patient Initial)

The reason for the request for my information: _____

_____

Re-disclosure: I understand that my treatment information released under this consent may be re-disclosed by the recipient of the information and may 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 this information is from records protected by Federal confidentiality rules. The Federal rules prohibits such person(s) from making any further disclosure of this information without specific written consent of the person authorizing this release or as otherwise permitted by 42 CFR part 2.

Expiration: This authorization will expire in ninety (90) days after the date below, or sooner by choice, in which case this authorization will expire on _____ (insert date), except to the extent action has already been taken in reliance upon this authorization. You may not indicate there is "no expiration," "does not expire," or "none."

Revocation: I understand that I may revoke this authorization at any time by notifying, in writing, the Medical Records Custodian (address noted below). I further understand that the revocation will not apply to information that has already been released in response to this authorization.

Authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand the provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law.

If I have questions about disclosure of my health information, I can contact the Medical Records Custodian.

Signature of Patient/Legal Representative_____ Date_____

If signed by Legal Representative, Relationship to Patient _____

*Patient's Date of Birth: _____

**The above information is required in order to verify the identity of the patient and to locate the patient's medical information.*

Failure to fully and legibly complete this authorization for release of medical information may result in the inability of this authorization to be honored.

You may print and mail your completed authorization to the following:
Medical Records Custodian
LCA Vision 7840 Montgomery Road
Cincinnati, Ohio 45236
Or
Fax: (513) 354-5774

Please allow for three weeks for the fulfillment or transfer of your medical record request. This is a general estimate, and could require more or less time depending on several factors like when you had your procedure and the LasikPlus center in which 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 because to ensure we protect your patient information there is not a way to expedite the records fulfillment process.

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