OFFICE PARK EYE CENTER

6 OFFICE PARK DRIVE
JACKSONVILLE, NC 28546-7325
PHONE: (910) 355-3937
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CAROL A. JOHNSTON, MD
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Medical Records Release

Patient Information:
Name of Patient: _____ Date of Birth: _____
Address: _____ Phone #: _____
City, State, Zip: _____

Information to be released from: _____
(FULL MAILING ADDRESS NEEDED, PHONE & FAX NUMBER)
_____

Information to be sent to: _____
(FULL MAILING ADDRESSED NEEDED, PHONE & FAX NUMBER)
_____

Information to be released:
___ The most recent pertinent information (office notes, labs, radiology reports, medication lists and special testing)
____ Completion of Disability, DMV, Non-Profit Organizations and/or FMLA form(s).

Treatment Dates: _____
____ Office Notes ____ Diagnostic Testing
____ Specific health information _____

___ I DO __ I DO NOT authorize release/request for information regarding drugs, alcohol, HIV, and/or mental health.

The information below is being disclosed for the following purpose:
____ Continued Care (Information being sent directly to another physician/healthcare facility)
____ Personal ____Legal ____Insurance ____ Other (please specify) _____

This authorization shall be in effect until the information has been forwarded/obtained as requested unless specified - _____
(PLEASE SPECIFY A DATE AND/OR EVENT THIS RELEASE WILL EXPIRE)

Patient Information
I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to revoke the authorization by sending a written notification to the address above and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information (PHI) as described in this document. I can do this by written notice to the medical record department at Onslow Ophthalmology, PA dba Office Park Eye Center.

I agree to pay all charges for copies of medical records when they apply.

_____ _____
Signature of Patient of Authorized Personal Representative **Date**

Relationship to Patient _____

Request Received by: _____ Date: _____