GUEST • MALACH
EYE SPECIALISTS

21931 East 9 Mile Road • St. Clair Shores, MI 48080
Phone (586) 210-2465 • Fax (586) 204-2473
www.GuestMalachEye.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name: _____ DOB: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____

RELEASE RECORDS FROM

I authorize the following physician, practice, hospital, or healthcare facility to release my medical information:

Physician/Practice/Facility: _____
Address: _____
City/State/ZIP: _____
Phone: _____ Fax: _____

RELEASE RECORDS TO

Guest Malach Eye Specialists
21931 East 9 Mile Road, St. Clair Shores, MI 48080
Fax: 586-204-2473 | info@guestmalacheye.com | Phone: 586-210-2464

INFORMATION TO BE RELEASED

- ☐ Complete medical record
- ☐ Most recent office/consultation notes
- ☐ Ophthalmology/optometry examination records
- ☐ Diagnostic testing and reports
- ☐ OCT images and reports
- ☐ Visual field testing and reports
- ☐ Fundus photographs / retinal imaging
- ☐ Corneal topography/tomography
- ☐ Biometry / IOL calculations
- ☐ Operative and surgical reports
- ☐ Pathology and laboratory results
- ☐ Medication list
- ☐ Relevant correspondence and referral records
- ☐ Other: _____

Dates of Service: ▢ All available dates ▢ From _____ to _____

Purpose: ▢ Continuity of care ▢ Transfer of care ▢ Patient request ▢ Other: _____

PATIENT AUTHORIZATION

I authorize the healthcare provider or organization identified above to disclose the medical information specified in this authorization to Guest Malach Eye Specialists.

I understand that I may revoke this authorization at any time by providing written notice, except to the extent that action has already been taken in reliance on it. Signing this authorization is voluntary, and my treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon signing except as otherwise permitted by law. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations. I am entitled to receive a copy of this authorization. A photocopy, electronic copy, or facsimile of this authorization may be treated as valid as the original. Unless revoked earlier, this authorization expires one year from the date of signature.

Patient Signature: _____ Date: _____

If signed by someone other than the patient:
Representative Name: _____ Relationship/Authority: _____
Representative Signature: _____ Date: _____

FOR OFFICE USE

Request Sent: _____ Sent By: _____ Method: ▢ Fax ▢ Mail ▢ Electronic
Records Received: ▢ Yes ▢ No Date Received: _____ Follow-Up Needed: ▢ Yes ▢ No