REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION
TO PIEDMONT EYE CENTER

TO: _____
(Name and Address of Health Care Facility releasing information)

Name of patient identified in the
health information to be released: _____

Patient's Date of Birth: _____ / _____ / _____ Last Four Digits of Social Security#: _____

Patients Primary Contact Number: _____

Patients Billing Address: _____

NAME AND ADDRESS OF ORGANIZATION, OR INDIVIDUAL, TO WHOM INFORMATION IS TO BE **RELEASED** TO:

Piedmont Eye Center, Inc.
116 Nationwide Drive, Lynchburg, VA 24502
Phone (434) 947-3984 Fax (434) 947-5950

PURPOSE(S) OR NEED: Information is to be used by the organization or individual for: TREATMENT

INFORMATION REQUESTED: Check applicable box(es)
□ All ophthalmic records/eye exams, office notes, visual fields, diagnostic testing results from prior 2 years.
□ Entire Medical Record (leaving nothing out)
□ Pathology and lab records
□ Radiology and x-ray records
□ Glasses & Contact Lens Prescriptions
□ Billing records
□ Other (specify) _____

As the person signing this authorization, I understand that I am giving my permission for confidential health information to be released to Piedmont Eye Center, Inc. The health information will be sent to Piedmont Eye Center by fax or mail unless otherwise specified. This authorization is subject to revocation at any time. Without prior revocation, this authorization will automatically expire upon satisfaction of the need for disclosure or 1 year from this date.

Patient Signature (or legal guardian):_____

Relationship to patient: _____ Date of Signature: _____