Patient Authorization for Release of Health Information

ocli.net | 1-866-SEE-OCLI (1-866-733-6254)

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if my health information is used or disclosed, the released information may no longer be protected by privacy regulations issued by the federal government.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

Patient Name: _____ Patient Date of Birth: _____

Patient Address: _____
City State Zip

To: _____
(Doctor's name and address)

Phone: _____ Fax: _____

I hereby authorize and request you to release the complete history records in your possession, concerning my illness and/or treatment during the period from _____ to _____.

Kindly forward these records to:

Name: _____

Address: _____
City State Zip

Phone: _____ Fax:_____

The patient or the patient's representative must read and initial the following statements:

a. I understand that my health care and payment for my health care will not be affected if I do not sign this form. INITIALS: _____

b. I understand that I may see and copy the information described on this form if I ask for it, and that Ophthalmic Consultants of Long Island will give me a copy of this form after I sign it. INITIALS: _____

c. I understand that this authorization will expire on _____. INITIALS: _____

d. I understand that I may revoke this authorization at any time by notifying Ophthalmic Consultants of Long Island in writing, but if I do revoke it, the revocation will not have an effect on any actions Ophthalmic Consultants of Long Island took before it received the revocation. INITIALS: _____

Purpose: ☐ Transfer of Care ☐ Insurance Eligibility Benefits ☐ Personal ☐ Specialist/Second Opinion

Delivery options: ☐ Pick up ☐ Patient Portal ☐ Mail to above address

☐ Fax Number: _____ ☐ Email: _____

_____
Signature of patient or patient's representative (state relationship if representative)

There is a charge of $.75 per page for any additional requests

Fax Form to 516-240-6540 or Email to medicalrecordsrequest@ocli.net