

MEDICAL RECORD REQUEST/RELEASE AUTHORIZATION

SECTION 1:

Patient Name: _____

Date of Birth: _____ Phone #: _____

SECTION 2: (Please check one)

_____ I hereby authorize Jonathan Noble, OD & Associates PLLC to send the record of my care to:

_____ I hereby authorize Jonathan Noble, OD & Associates PLLC to request the records of my care from:

Name: _____

Address: _____

Phone: _____ Fax: _____

SECTION 3:

For the purpose of: ___ Consultation ___ Treatment ___ Claim settlement ___ Changing Provider
Other: _____

SECTION 4: (Please check one)

___ Release all information in my medical record (including any information regarding mental health, drug or alcohol abuse, sexually transmitted diseases, or HIV).

___ Release all information in my medical record, except for: _____

___ Release only the following specific information in my medical records (you may specify specific medical conditions, treatments, tests, and specific dates): _____

SECTION 5:

I understand that my records are maintained in accordance with all Federal and State laws and cannot be disclosed without my written consent except as otherwise provided by law.

Any information released or received as a result of this consent shall not be further relayed in any way to any other person, organization, entity or other without an additional written consent from me or as otherwise provided by law. I may withdraw this consent by giving written notification to the above party at any time prior to the disclosure or release of the information. In the absence of my prior withdrawal, this consent will expire 180 days after it is signed.

I have read this notice and consent prior to signing and I understand its contents.

Signed: _____ Date: _____

Signature of Patient *or Legal Guardian if under 18.

*Relationship to Patient: _____

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