



Medical Records Release

This form authorizes Nalini Healthcare PLLC to release your medical records TO another provider or entity.

PATIENT INFORMATION:

Patient Name: _____

Date of Birth: ____/____/____

I authorize **Nalini Healthcare PLLC** to release the following designated medical information. The reason for this release is for further treatment / continuation of medical care.

INFORMATION TO BE RELEASED:

- All health information (complete medical records)
- Copy of complete medical records including results of diagnostic testing
- Copy of contact lens prescription
- Copy of spectacle lens prescription
- Past/Present Medications
- Blood Workup Results
- Fundus Photography / OCT Images
- Progress Notes
- Radiology Reports
- Other: _____

RELEASE RECORDS TO:

Practice/Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Secure Email: _____

IMPORTANT INFORMATION:

- **Expiration:** This authorization is valid until the earlier of the occurrence of the death of the individual, permission is withdrawn in writing, or ____/____/____ (termination date).

- **Re-disclosure:** I understand the information disclosed by this Authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA. The recipient has no duty to protect its confidentiality.
- I have the right to refuse to sign this Authorization.
- I have the right to receive a copy of this Authorization.
- I have the right to inspect or copy the protected health information to be used or disclosed.
- It is completely my decision to sign this authorization. Treatment will not be refused if I choose not to sign.
- I may revoke this authorization at any time by contacting in writing, fax, or email the Privacy Officer noted in the Notice of Privacy Practices.
- Fees/charges will comply with all laws and regulations applicable to release of information.

I HAVE READ AND UNDERSTAND THIS FORM. I VOLUNTARILY AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

IF I AM SIGNING FOR A MINOR CHILD, I ATTEST I HAVE LEGAL AUTHORITY TO MAKE MEDICAL DECISIONS FOR THE DESIGNATED MINOR.

Print Patient Name DOB (unless signing for minor)

_____ Date: ____ / ____ / ____

Patient or Legally Authorized Individual Signature

Printed Name (if signed on behalf of patient) Relationship / DOB of minor (if signing for minor)