Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me , by releasing a copy of my medical records, or a summary of a narrative of my protected health information, to Corridor Family Eyecare listed below:

Corridor Family Eyecare
5350 Kirkwood Blvd. Ste. 100
Cedar Rapids, IA 52404
319-365-2946 Office
319-365-2948 Fax
www.corridorfamilyeyecare.com

The information you may release subject to this signed release form is as follow:

- ❑ Complete Records
- ❑ Care Plans
- ❑ Pathology Reports
- ❑ Hospital Reports
- ❑ History & Physical
- ❑ Lab Reports
- ❑ Treatment Record
- ❑ Medication Record
- ❑ Progress Notes
- ❑ Radiology Reports
- ❑ Operative Reports
- ❑ Other(please specify below)

_____

_____

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any other causative agent of AIDS with the rest of my medical records. **Initial:**_____ **Date:**_____

Release my protected health information to the following: Corridor Family Eyecare.

The purpose/reason for this release of information is as follows:

_____

_____

I understand that Corridor Family Eyecare will provide this information within 15 days from the receipt of request and that a fee for preparing and furnishing this information may be charged according to rules set forth by the Iowa State Board of Medical Examiners.

Signature:

_____ _____
Patient Name | Signature of Patient or Personal Representative

_____ _____
Patient Date of Birth or Social Security Number | Printed Name of Patient or Personal Representative

_____ _____
Date | Description of Personal Representative's Authority