THE EYE CENTER
OPHTHALMIC ASSOCIATES, P.A.

Christopher R. Bruno, MD
Board Certified Ophthalmologist

Medical Record Request Fee

List below are charges for copying medical records and/or filling out medical forms.

Patient's Name: ____ DOB: __________________

Copying Medical Records	$1.00 Per Page
Medical Forms	$10.00 Per Form
DMV (Division of Motor Vehicle) Forms	$10.00 Per Form
Disability Forms	$10.00 Per Form
Other:	$10.00 Per Form

In order to comply with federal laws including HIPAA, as well as New Jersey state and federal statues, this office must have a signed authorization from the patient / responsible party stating who we are authorized to release information to. Also, by signing below you are stating you are aware of our office's fees. Please be sure to sign the form. Unsigned requests cannot be processed.

____ _______________

Signature of Patient or Responsible Party *Date*

Authorization to Release Medical Information

I authorized the use or disclosure of the above-named individual's Protected Health Information (PHI), as described below covering the data range indicated.

Releasing Records **From**:
____
____

Releasing Records **To**:
____
____

Requesting Records from: ____/____/_______ through ____/____/_______

The information to be disclosed shall be limited to that information necessary to fulfill the stated purpose (s) and may include the following items.

_____**Medical Records** _____**Billing Records** _____________**Other**

* History and Physical examination
* Consultation
* Other: ______________________

* Diagnostic Testing
* Treatment Recommendation

This authorization maybe revoked by me at any time except to the extent that Ophthalmic Associates had already acted in reliance on this authorization. If I revoke this authorization, I need to do so in writing and mail or hand deliver it. If not revoked by me, this consent will be terminated 30 days after this form has been signed. I have a right to review the information disclosed. I understand that I need not sign this form in order to insure healthcare treatment, payment, enrollment in my heath plan or eligibility for benefits. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient or no longer be protected by this rule.

Patient's Signature/ Legal Representative: ________________________________ Date: ____________
Legal Representative Relationship to Patient: ______________________________

Witness/ Staff Signature: ____ Date: ___________

Date: ________ Staff Initials: _______Faxed: _______ Mailed: _______ Given to Patient: _______

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