Mid Coast Vision Care

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Date: _____

TO:_____

PATIENT: _____
DATE OF BIRTH: _____

I, , authorize Lyndon W. Morgan, MD, his employees and agents to disclose and discuss my treatment records relating to _____with_____.

Please forward (X applicable lines)

_____ A summary or copy of my treatment record information, including history, dates, course ad summary of treatment received.
_____ Treatment records on file from other health care practitioners.
_____ Statement I have added to my treatment records with responses if any.
_____ Only _____

This information may be used for (X applicable lines)

_____ Ongoing treatment/ aftercare
_____ Transfer of care
_____ Other _____

(Please circle) I DO or I DO NOT authorize the release of any information relating to the diagnosis or treatment of ALCOHOL OR DRUG ABUSE under this authorization. If I authorize the release of this information, I understand that such information cannot be re-disclosed by a recipient without my specific consent.

(Please circle) I DO or I DO NOT authorize the release of any information relating to the diagnosis or treatment of MENTAL HEALTH under this authorization. (Please circle) I DO or I DO NOT authorize the release of information relating to HIV/AIDS.

(Please circle) I DO or I DO NOT want to review this information before it is released. I understand that any such review must be supervised.

My consent to release these records is effective until _____, and I authorize future disclosures regarding these records to the same individuals or entities during this time period.

I understand that:

I can revoke all or part of this authorization at any time by notifying Dr. Morgan's office in writing, subject to the rights of anyone who received or disclosed information prior to receiving my revocation. I can refuse to disclose all or some of the information in my treatment records.
A refusal or revocation to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
I can have the copy of this form upon request.
I can cross out any provision on this form with which I disagree.
Patient records may be transferred by a fax machine.

_____ _____
SIGNATURE OF PATIENT or LEGALLY APPOINTED REPRESENTATIVE: DATE