VISIONARY EYECARE SURGERY, INC.
Mason F. Bias, M.D., F.A.C.S.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
Please read all information before signing the authorization form

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________ Social Security #: ______________

______________________ Phone Number: ______________

herby request and authorize *VISIONARY EYECARE AND SURGERY, INC*. to release a copy of my medical records

from ______________ to ______________ *(if left bank only the past two (2) years will be disclosed)* to the below:

month/year month/year

Name: ______________________ Phone #: ______________

Address: ______________________

______________________ Fax #: ______________

Reason for Request: (please check one below)

❍ Personal ❍ Transfer of Care ❍ Further Medical Care ❍ Insurance ❍ Other

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I certify that this request has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I Understand that I any be charged a fee for records copies as applicable by state and federal laws. I do not need to sign this authorization in order to receive treatment. I also am aware that I may revoke this authorization by notifying the disclosing medical records department in writing and is effective upon receipt. Once my medical records is disclosed as requested, they may no longer be protected by federal and status privacy laws, and could be re-disclosed by the person(s) receiving it.. This authorization will automatically expire: (1) upon satisfaction of the need for disclosure or (2) one year from the date signed.

______________________ ______________

Signature Date

Relationship to Patient:

❍ Self ❍ Court Appointed Guardian ❍ Legally Appointed Healthcare Agent ❍ POA

❍ Medical POA ❍ Court Appointed Personal Representative of Deceased ❍ Other ________________

For Office Use Only:

Patient Acct #: ____________ Date Released: ____________ Staff Initials: ______________

Release Method: Faxed Patient Pick Up Mailed to Authorized Address Mailed to Patient

Other: ____