Name: ______________________________ Date of Birth: ____________

Request for Medical Records Release

(Required by the Health Insurance Portability and Accountability Act, HIPAA, 45 C.F.R. Parts 160 and 164.)

I authorize you, ________________________________, to release my protected health information and request that you send a copy of my medical records or a summary or narrative of my protected health information, to Hester Ophthalmology and Darrell E. Hester, M.D. This medical information may be used by Hester Ophthalmology and Dr. Hester for medical treatment or consultation.

Effective period: This authorization for release of information covers (check one):

- ☐ the period of healthcare from *(date)* ____________ to *(date)* ____________
- ☐ All past, present, and future healthcare records

Extent of Authorization: I authorize the release of (check all that apply):

- ☐ My complete health record.
- ☐ My complete health record except for the following:
  - ☐ Mental health records
  - ☐ Alcohol/Drug abuse treatment
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Other (please specify):__________________________

I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

________________________________ ______________
Signature of patient (or personal representative) Date

________________________________ ______________
Printed name of patient (or personal representative) Relationship to patient

1604 Physicians Drive, Suite 103, Wilmington, NC 28401
phone: (910) 343-8125 fax: (910) 762-0852 www.HesterVision.com