Corrective Eye Center

Medical Records Release Form

Willoughby Hills, Independence and Rocky River

Phone: 216.574.8900 Fax: 216.731.2627

1. Patient Information:

Patient Name: _____ Date of Birth: _____

Address: _____ State: _____ City: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

2. Release Information From: Corrective Eye Center ☐

Organization/Person: _____ Phone number: _____

Address: _____ Fax: _____

3. Release Information To: Self: ☐

Organization/ Person: _____ Phone number: _____

Address: _____ Fax: _____

4. Dates of Service: From: _____ to: _____

Reason for Records/ Documents: _____

5. Delivery Method: Fax ☐ Mail ☐ Pick Up in Office ☐

I understand/authorize Corrective Eye Center to release/request my medical information as described above. I understand that my medical records/ protected health information cannot be released unless I sign this form.

I understand that there may be charge for copying and release of information and accept financial responsibility.

Patient Signature/Patient's POA: _____

Printed Name: _____ Date: _____