AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name:_____ Date of Birth: _____ Phone Number:_____

I authorize LasikPlus to release the following information from my medical record:

- □ Complete Treatment Record without limitation
- □ Treatment Record of the following date(s) _____
- □ Billing and payment records
- □ Other (describe): _____

I authorize the following person(s) or organization to receive the information:

Name _____
Street Address _____
City, State, and Zip Code _____
I prefer that you fax my records to: _____

The reason for the request for my information: _____

This Authorization will expire in ninety **(90) days** after the date below, or sooner by choice, in which case this Authorization will expire on _____ _____(insert date), except to the extent action has already been taken in reliance upon this Authorization. You may not indicate there is "no expiration," "does not expire," or "none."

I authorize the release of any information contained in my treatment records that might contain sensitive information including information concerning diagnosis and/or treatment of alcohol or substance abuse, drug-related conditions, mental health conditions, developmental disabilities, sexually transmitted diseases, communicable diseases, genetic testing, and/or HIV/AIDS related conditions.

I understand that treatment information released pursuant to this Authorization could be subject to redisclosure by the recipient and may no longer be protected by Federal law. If the information released under this consent includes alcohol or drug treatment records, the person(s) receiving this information are hereby notified that the Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2.

I understand that my refusal to sign this Authorization will not affect my ability to obtain treatment, payment, enrollment or eligibility for benefits.

I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. I understand that I may revoke (cancel) this Authorization at any time by notifying, in writing, the Medical Records Custodian (address noted below). I further understand that the revocation will not apply to information that has already been released in response to this Authorization.

I understand that LasikPlus and its Workforce are released from legal responsibility or liability for disclosing protected health information authorized by my signature below. LasikPlus reserves the right to send the record to the physical mailing address of the recipient if the medical record is too large to send/receive by email or fax.

_____
Printed Name of Patient

_____
Date

_____
Signature

You may email your completed Authorization to:

medicalrecords@lasikplus.com

By fax or regular mail:

LCA Vision
Medical Records Custodian
7840 Montgomery Road
Cincinnati, Ohio 45236
Fax: (513) 513-672-9749

Note: Please allow for three weeks for the fulfillment or transfer of your medical record request. This is a general estimate, and could require more or less time depending on several factors like when you had your procedure and the LasikPlus center in which you had your procedure. If your medical records are needed for an important appointment or procedure with another doctor's office, please plan with the fulfillment period in mind. To ensure we protect your patient information there is not a way to expedite the records fulfillment process.