# Record Release Form (HIPAA)

I , _____, DOB:_____
authorize **Precision Eye Institute** to request and share health information with the following entities for the purpose of ensuring an accurate and complete documentation of my past/present medical history.

This information requested/released may include the following:

- Diagnosis
- Test results
- Treatments
- Alcohol/drug treatments and status
- Communicable diseases
- Genetic information and family history
- Billing information (insurance)

*****If you choose to decline any request/release of health information at this time, please sign here*****

**Date Declined:_____ Signature:_____**

**Please complete the following if we can request/release information at this time.**

**Primary Care Provider/Office: _____**

**City: _____**

Other Provider(s):

_____

_____

Family/Friend (In case of emergency) _____

**You may withdraw this permission at any time in writing.**
**You may request a copy of this form at any time.**

**I have read and understood this Record Release Form and authorize Precision Eye Institute to request/release information with the entities I have listed above.**

**Print Name: _____ Date: _____**

**Patient Signature: _____**

*** if signing for someone else***
Guardian/Representative Signature: _____ Relationship: _____