VISIONARY EYE

SHEHZAD BATLIWALA, D.O., MGM

# Patient Medical Records Release Form

**I do hereby consent and authorize my medical records to be released.**

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____ SSN# _____

This information is to be released **TO**:

_____

_____

_____

City State Zip

_____ _____

Phone Fax

This information is to be released **FROM**:

_____

_____

_____

City State Zip

_____ _____

Phone Fax

**Information being requested:**

- ☐ Complete Record
- ☐ Records of care from the following dates: _____ to _____

State statute requires special permission to release otherwise privileged information. Please check applicable categories for release of records.

- ☐ Mental Health
- ☐ Developmental disabilities
- ☐ AIDS related diagnosis
- ☐ Alcoholism
- ☐ AIDS test results
- ☐ Drug abuse

**Purpose or need for disclosure:**

- ☐ Further medical care
- ☐ Payment of ins claim
- ☐ Vocational rehab eval
- ☐ Legal investigation
- ☐ Application for insurance
- ☐ Disability determination.
- ☐ Personal
- ☐ Other

Patient Signature: _____ Date: _____

Signature of Legal Representative: _____ Date: _____

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