Central Eye Care, P.C.
Pediatric Ophthalmology and Strabismus

Medical Records Release Form

Patient's Name (Printed): _____ *Patient's Date of Birth:* _____

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

Phone Number: _____

I authorize and request the release of medical records from:

Name of Recipient	*Phone Number*
Address	*Fax Number*
City *State* *Zip Code*	

To be sent to:

Name of Recipient Shawn Gappy, MD/Central Eye Care, P.C.	*Phone Number* (248) 607-3114
Address 23411 John R. Rd., Suite 4	*Fax Number* (248) 307-7188
City *State* *Zip Code* Hazel Park MI 48030	

By my signature, I authorize that my protected health information (PHI) may be used or disclosed by the sender. I authorize my PHI to be forwarded to the receiver. I understand that the PHI, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may lose the protection of confidentiality under the privacy rules. I understand that I have the right to inspect and copy the PHI that will be used or disclosed pursuant to this authorization. I understand that the sender and receiver will not condition any aspect of my treatment, payment, and enrollment in the health plan or eligibility for benefits on whether or not I sign this authorization. I understand that I am under no obligation to sign this authorization. I understand this authorization will expire 60 days after the date I signed it. I understand that this authorization may be revoked in writing at any time. By my signing the authorization, I acknowledge that I have read and understand this authorization. Further, I give my authorization to the sender to use or disclose PHI in accordance to the terms of the authorization.

*Patient/Parent/Guardian's Signature:*_____ *Date:* _____

*Parent/Guardian's Printed Name (If Applicable):*_____