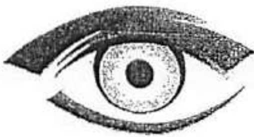

POST FALLS
OPTOMETRIC PHYSICIANS

185 W. 4TH AVENUE, SUITE A • POST FALLS, ID 83854 • P: 208-773-7434 • F: 208-777-0836 • WWW.POSTFALLSOP.COM

Authorization to Release Medical Records and Information

Please fully complete this form. State and Federal law require this information in order for our office to complete your request.

Patient Information

Patient's Full Name ____________________ Date of Birth ____________

Current Address ____________________

City ____________________ State ________ Zip ________

Home Phone ____________________ Cell Phone ____________

I hereby authorize you to release my records to:

Name of Doctor or Facility Post Falls Optometric

Address 185 W. 4th Ave Suite A

City Post Falls State ID Zip 83854

I hereby authorize my records to be released from the facility listed below to Post Falls Optometric Physicians.

Name of Doctor or Facility ____________________

Address ____________________ Phone ____________

Fax ____________ City ____________________ State ________ Zip ________

Purpose of Records Release

☐ Moving/Relocation
☐ Personal Use
☐ Change Doctors
☐ Other ____________________

Information to be Released:

☐ Physician notes and records (limited to two years of information)
☐ Diagnostic Testing
☐ Operative Reports
☐ Other ____________________

I have reviewed and understand this authorization to release medical records. I also understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer under federal law.

This authorization will expire 90 days from the date of signing, and may be revoked at any time, provided you do so in writing and except to the extent we have already used or disclosed the information in reliance on the authorization. If you wish to revoke the authorization, please submit your written request to Post Falls Optometric Physicians.

I hereby authorize you to release/fax my records to recipient listed above. I understand the risk involved in faxing records and that the recipient cannot guarantee that confidentiality. All faxed information will contain a confidentiality statement and instruction for returning misdirected information.

____
Signature of Patient or Legally responsible person

____
Date

Relationship: ____________