AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

ALL ITEMS ON THIS AUTHORIZATION MUST BE COMPLETED IN FULL TO PROCESS

I hereby authorize (circle one) Cockeysville Optical **or** _____

to provide copies of the medical records with testing, including:

____ the last three years of care at their location to present.

____ a copy of my entire office medical and eyecare records.

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Patient Signature: _____

This information is to be released to:

Crossroads Eye Physicians
McDonogh Crossroads
23 Crossroads Drive, Suite 310
Owings Mills, MD. 21117
410-581-1500
410-581-0577 (fax)

- This information may be used by the person I authorize for medical treatment, billing, or claims.
- I have the right to revoke authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal law.
- This Authorization Form was drafted to comply with the Health Information Portability and the Accountability Act and the Maryland Confidentiality Act.