MATOSSIAN EYE ASSOCIATES
An affiliate of PRISM Vision Group

Medical Records Release Form - Patient Request

Account Number: _____

MEA_HIPAA_P101_001_A

Patient Information

Patient Last Name	First Name	Middle Name	Maiden Name	
Address (Street or Box)		City	State	Zip Code
Home Phone Number	Cell Phone Number	Date of Birth		

Information Requested

- ☐ Chart Notes
- ☐ Dictation
- ☐ Complete Medical Records
- ☐ Records from _____ to _____
  DATE DATE

Exclusions

- ☐ Alcohol / Drug
- ☐ Behavior / Mental Health / Psychiatric
- ☐ Sexually Transmitted Diseases
- ☐ HIV / AIDS
- ☐ Other (Please Specify) _____
- ☐ No Exclusions

*Exclusions do not apply to Treatment, Payment, or Health care operations.

Request Purpose

- ☐ Continuing Medical Care
- ☐ Disability Determination
- ☐ Worker's Comp
- ☐ Insurance Claim
- ☐ Application for Insurance
- ☐ Legal
- ☐ Other (Please Specify) _____

RELEASE TO

Name		
Phone	Fax	
Address		
City	State	Zip Code

REALEASE FROM

Name		
Phone	Fax	
Address		
City	State	Zip Code

Restrictions & Revocations

This authorization is limited to the following time-period:

This authorization is limited to the following treatment:

Unless revoked, this authorization will be valid for six (6) months from the date of my signature below. To revoke this authorization, I must submit, in writing, to Associated Retinal Consultants, LLC, Attn: Medical Records, 1000 Galloping Hill Road, Suite 305, Union, NJ 07083, or to the site where I submitted the Authorization.

Re-disclosure: I understand the information disclosed by this authorization may be subject to re-disclosure by the recipients and no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) of 1996. I release Associated Retinal Consultants, LLC ("ARC") dba Matossian Eye Associates, an Affiliate of PRISM Vision Group, its employees, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Disclaimer: ARC will make every effort to include all requested information and records, but information may be inadvertently excluded on occasion. We apologize for any accidental omissions. If you are aware of any omission, please bring it to our attention.

Service Charge: I understand that, as a courtesy to patients, ARC offers one set of copies free of charge during the service period. If I request more than one set of copies of any or all of my records, during any 12-month period, I may be charged $1.00 per page, not to exceed $100.00, for each set of records that have previously been provided during that time.
(§ 13:35-6.5(c)4)

_____ _____
Patient Signature Date

_____ _____
Legal Representative Printed AND Signature (if applicable) Relationship to Patient

FOR ARC USE ONLY

Identity of Requestor verified via: ☐Photo ID ☐ Matching Signature ☐ Other (Specify) _____

Records sent by (Print Employee Name) _____ on (Date) _____

Method of Release: ☐ Self Pick-Up ☐ UPS / FEDEX (Circle One) ☐ Secure Fax