

# ACCURATE VISION CLINIC

3401 MINNESOTA DRIVE, SUITE 200  
ANCHORAGE, ALASKA 99503

T: 907.272.9800  
F: 907.277.1398

E: info@accuratevisionclinic.com

[WWW.ACCURATEVISIONCLINIC.COM](http://WWW.ACCURATEVISIONCLINIC.COM)

## Records Release Authorization

To insure compliancy with federal regulations, regarding the privacy act known as HIPPA (Health Information Portbilty and Accountability Act), we will need the following information to identify you properly and your written authorization to release and/or request your optometric records to be sent to/from another provider.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Nickname \_\_\_\_\_  
Date of Birth \_\_\_\_ - \_\_\_\_ - \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

I authorize Accurate Vision Clinic, Dr. Crawford, or his representatives to release information to Dr. \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

----- or -----

I authorize Dr. \_\_\_\_\_ to release information to Accurate Vision Clinic and/or Dr. Crawford.  
Phone 907.272.9800 Fax 907.277.1398

### Select Request:

- Complete Copy of Optometric Records including OCT & VF Test Results
- Glasses Prescription
- Contacts Prescription
- Last Exam Information
- Other \_\_\_\_\_

Information listed above will be disclosed for the following purpose (circle one):

Continued Care / Terminating Care / Seeking Second Opinion / Personal Use /  
Legal Use / Other \_\_\_\_\_

Records Are To Be (select option):

*If records are greater than 15 pages they will be mailed unless otherwise specified.*

- Picked Up in Person
- Mailed to: \_\_\_\_\_
- Faxed to: \_\_\_\_\_

Please note that only the 1st set of records will be issued for free. Any additional sets will incur a fee of \$25 for every 25 pages copied. Initial \_\_\_\_\_ Date \_\_\_\_\_

Patient or Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_