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

Records Release Authorization

To insure compliancy with federal regulations, regarding the privacy act known as HIPPA (Health Information Portbility 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 _____