



CHARLOTTE OPHTHALMOLOGY

Center for Sight

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REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____

Date Of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Which dates of service would you like released? _____

How would you like your information released:

- Mail Fax Pick Up
Email Electronic Format (when applies)

Information Released To:

Information Released From:

Name (health Care Provider)

Name (health Care Provider)

Street Address

Street Address

City State Zip

City State Zip

Phone Fax

Phone Fax

Patient Information: This authorization shall be in effect until the information has been forwarded as requested. I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no be longer be protected by federal or state law.

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed.

I understand that records that are released will include any information related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS, unless otherwise noted.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to the HIPAA Privacy Officer, Charlotte Ophthalmology Clinic, 16610 Birkdale Commons Parkway, Huntersville, NC 28078.

Signature of patient or legal representative

Date

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