Aker Kasten
Eye Center

Records Release Authorization

Date: _____

FROM: _____
Doctor/Hospital

_____
Address

I hereby authorize and request you to release **TO :**

Aker Kasten Eye Center
1445 N.W. Boca Raton Blvd.
Boca Raton, FL 33432
Phone: 561-338-7722
Fax: 561-338-7785

The complete history of medical records in your possession, concerning my illness and/or treatment.

During the period from _____ to _____

Name: _____ Date of Birth: _____

Address: _____

Signature: _____ Date: _____
(If you are a relative, state your relationship to patient)

Witness: _____ Date: _____

We must receive your records prior to your scheduled appointment with us or your appointment will have to be rescheduled.

Office Use Only
Received Records Date: _____ Initials: _____

The PHI (Protected Health Information) contained in this FAX is **HIGHLY CONFIDENTIAL**. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such. Thank you.