

INSTRUCTIONS FOR RELEASE OF MEDICAL INFORMATION

In order to process your request, you must complete the authorization on the reverse side.

The following instructions are designed to assist you in completing this form.

1. **Patient identification** – write the complete name and the date of birth of the person whose records are being requested.
2. **Release information to** – give the complete name and address of the person or business to whom the records are being released.

Check the appropriate option for either picking up your records or having them mailed.
If you intend to have someone pick up your records for you then you must specify in writing who this individual is, and they may be required to show a valid photo ID when picking up these records.
3. **Information to be released** – check off all that apply for the information you wish to have released and specify the reason you are requesting these records.
4. **Authorization** – read, sign and date the authorization. If you are signing as a legal guardian, we must have legal proof of representation.
5. **Highly confidential information** – read, sign and date the highly confidential authorization.

YOU MUST COMPLETE ALL AREAS ON THIS FORM, IF ANY AREAS ARE LEFT BLANK THIS FORM WILL BE RETURNED FOR COMPLETION.

Return your signed authorization to: Newton Wellesley Eye Associates, P.C.
ATTN: Medical Records
2000 Washington Street, Ste. 462
Newton, MA 02462

NOTE: there is a \$15 fee for a copy of your medical records; please include payment with your signed authorization.

(**In some cases this fee may be waived, please be sure to specify the reason why you are requesting your records.)

(For HIPAA compliance purposes we can only release notes from our office, we cannot release notes previously transferred from another medical facility)

10/2022