Please Read

Patient Guidelines on Release of Information

In order for Carolina Eye Associates to process your request for information in a timely manner, we must receive **complete information**.

Please make sure you have included the following information**. Any information that is missing will result in your form not being processed and returned to you.**

- Please make sure all the **patient information** is filled out on the release form, including the patient's name, address and date of birth.

- Please have all areas pertaining to where **records are to be sent** or **to be sent from** is **completely** filled out.

- If records are to be **sent to another physician's office**, we must have the doctor's name, telephone, and FAX number, and/or complete mailing address.

- If you have an **upcoming appointment**, please note this on the top of the release so your records can be expedited for you by the date indicated.

- If you are a **caregiver** for someone and they are unable to sign, or **executor** of an estate, we will also need a copy of the **power of attorney** papers in order to release the records.

Request for paper copies of your medical records will be processed within 7 to 10 business days upon receipt of your signed release. Requests for electronic copies of medical records may be processed sooner.

Medical Records Department
Carolina Eye Associates
2170 Midland Road
Southern Pines, NC 28387
(910) 295-2100 or (800) 733-5357, extension 271 or 276
FAX (910) 295-4531

Patient's Request to Access Protected Health Information

Patient Name:			Chart #:
Mailing Address:			
City:	State:	Zip Code:	Birth Date:

Authorization & Information to be Released from Health Record or Have Access to other information

I authorize my health care professional to release the following information from my health record (s).

☐ Treatment Sheets (☐ All ☐ From _____/_____/_____ through _____/_____/_____.

☐ Complete Record

☐ Other (Specify):

OR ☐ I request inspection of the record. Please contact me at _____ to arrange for a mutually convenient time and location for inspection.

OR ☐ I request a summary or explanation of the requested information.

Authorization & Information to be Released from Billing Record

I authorize my health care professional to release the following information from my billing record (s) between the following dates: _____/_____/_____ through _____/_____/_____.

OR ☐ I request inspection of the billing record. Please contact me at _____ to arrange for a mutually convenient time and location for inspection.

OR ☐ I request a summary or explanation of the requested information.

Information is to be Released to:

☐ Doctor: ☐ Self ☐ Carolina Eye Associates Center:

Mailing Address:		
City:	State:	Zip Code:
Telephone:	Fax:	

Information is to be Released from:

☐ Doctor: ☐ Self ☐ Carolina Eye Associates Center:

Mailing Address:		
City:	State:	Zip Code:
Telephone:	Fax:	

Medical Records Release Format

I would like my records released in the following format ☐ Electronic Copy

☐ Paper Copy ☐ secure email (provide email address)_____

If you desire copies of your records in an electronic format, please specify which format that you would like to receive this by:

☐ **Carolina Eye's NextMD Patient Portal** ☐ CD

☐ Other electronic means (please list) _____

Consent

I understand there may be a fee for the summaries, explanation, or copies.

I authorize Carolina Eye Associates or the above doctor or institution to release the above noted information from my heath record(s).

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. The facility, its employees and officers and attending physician are released form legal responsibility and liability for the release of the above information to the extent indicated and authorized herein.

Patient Signature:	Date:
Witness:	

Request to Access Protected Health Information Instructions & Policy Guidelines

Requests for Copies of Medical Charts

Carolina Eye Associates is committed to protecting your health information and we are required by law to make sure that health information that identifies you is kept private. Our policies have been designed to protect your right to privacy and to allow you to control the release of information from your record.

Our medical records department handles requests for copies of patient medical records. Requests must be in writing so that we have a legal record of your request and to verify that you have given permission for the release of information. In order for your request to be processed you must complete the Patient's Request to Access Protected Health Information form that is available to download under 'Patient Forms' on our Forms & Downloads page. If you are a caregiver for someone and they are unable to sign, or you are the executor of an estate, we will also need a copy of power of attorney in order to release the records.

It usually takes 7 to 10 business days to process your request upon receipt of your signed release.

Copies for You, Your Other Doctor or Health Care Provider

There is no fee for this service.

Please mail or FAX to us your completed 'Patient's Request to Access Protected Health Information' form and include the date of any upcoming appointment you may have, so we can make sure the copied records get there on time. Please remember that it takes 7 to 10 business days to process your request.

Copies to an Attorney or to Other Legal Facilities

There is a fee for this service.

Please see your attorney about giving authorization to obtain information. They have their own authorization forms requiring your signature. We will notify them about the fee based on copy volume.

Contact Information

If you have any questions, please do not hesitate to call a staff member in our Medical Records Department at (910) 295-2100 or (800) 733-5357, extension 271 or 276.

For faster secure responses, we encourage you to utilize our Nextgen Patient Portal

You can FAX authorization requests to (910) 295-4531,

Email your request thru secure encrypted email to: medical.records@carolinaeye.com

or

Requests by mail should be addressed to:

Carolina Eye Associates, P.A.

Attn: Medical Records Department

2170 Midland Road

Southern Pines, NC 28387