BOHN, JOSEPH & SWAN EYE CENTER
PRIMARY & CORNEA EYE CARE IN ACADIANA

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Jonathan M. Joseph, M.D. and/or Kevin R. Swan, M.D. to release copies of the below specified medical records and information regarding treatment and examination rendered to me to:

Name: _____

Address: _____

_____

Phone Number: _____ Fax Number: _____

☐ Records for these dates of service: From_____ to _____.

☐ All medical records

☐ Other _____

The authorized copies of my medical records are to be:

☐ Picked up by the above referenced person

☐ Mailed to the above referenced person at the address indicated

☐ Faxed to the above referenced person at the fax number indicated

A photocopy of this authorization is to be accepted with the same authority as this original.
I understand that I have the right to revoke this authorization at any time by contacting this office with a verbal statement of revocation followed by a written notice within three business days. I understand that if the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

This authorization for release of medical records expires on:_____

Date:_____

Patient Signature:_____
(Or Other Person Legally Authorized To Sign on Behalf of Patient)

Print Name:_____ MRN:_____

Patient Date of Birth:_____

Last Four Digits of SSN:_____