CHESAPEAKE EYE CENTER

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Cataract/Implant Surgery/Lasik
Comprehensive Eye Care

Jason M. Yonker, M.D., FACS
Cataract/Implant Surgery
Glaucoma & Related Diseases

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Jennifer Sim, M.D.
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Chart Your Course to Quality Eye Care

CONSENT TO RELEASE INFORMATION

Patient _____ DOB _____

Provider releasing records:

Name _____
Address _____
City/State _____

Provider to receive records:

Name _____
Address _____
City/State _____

Medical information to be sent:

____ Entire medical record INCLUDING information developed by another provider which is part of the file documentation.

____ Entire medical record EXCLUDING information developed by another provider which is part of the file documentation.

____ Record of care from _____ to _____. INCLUDING information developed by another provider which is part of the file documentation.

____ Record of care from _____ to _____. EXCLUDING information developed by another provider which is part of the file documentation.

The record of care my INCLUDE/EXCLUDE any information relating to the treatment for substance abuse; mental health treatment; testing or treatment of STD's, hepatitis, and HIV/AIDS.

I authorize medical information to be released as indicated above. I agree that this release is valid for one year or until _____, but I may revoke my consent at any time upon written instruction.

_____ _____
Patient or Legal Guardian Date

_____ _____
Witness Date