Gallagher Eyecare

Dr. Joseph Gallagher

Authorization to Release Optometry Records

Patient Information:

Name (Print): ______________________________ Date of Birth: ____________________

Information To Be Released From:

Name of Facility or Provider: ______________________________

Information To Be Sent To:

Hill Opticians & Gallagher Eyecare
53 S. Main Street
Hanover, NH 03755
Phone: 603-643-2400
Fax: 603-643-4962

Requesting Provider: ____________________

Information To Be Released:

☐ Last 2 (or more recent) years of eye exam notes (Exam Summary, Special Testing, Etc.)

☐ Other: (Please Specify): ______________________________

Patient Authorization:

I understand that my records may contain information regarding a diagnosis or treatment. I authorize the use or disclosure of the above specified information to be retrieved for medical purposes only.

My Rights:

I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice to patients posted at the facility where your information is being released. I understand that once the health information I have authorized to be disclosed reached the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws.

Signature: ______________________________ Date: ____________________

(Patient, Guardian, or Authorized Representative)

This authorization will expire 90 days from the date signed.