Kelly eye center *for sight*

Dr. Michael Kelly Dr. Sean Smolenyak

CONSENT FOR RELEASE OF MEDICAL RECORDS

Patient's Name: _____

DOB: _____

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are part of my medical records. PLEASE NOTE: This authorization includes consent for release of alcohol, drug, psychiatric, and psychological information and any information relating to pregnancy, sexually transmitted diseases, HIV testing, AIDS, and AIDS related syndromes. It includes any information concerning cancer, cancer testing, and cancer results. I agree that a copy or fax of this authorization shall be as valid as this original release.

Information to be released from:

_____

_____

_____

To:

☐ Kelly Eye Center ☐ Self

☐ Other: _____

_____

Reason for request: _____

Patient's Signature: _____ Date: _____

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