Hearne Vision Care

29 East Poplar Street
North Vernon. IN 47265
Phone: 812-346-4646 Fax: 812-352-6262 Email: records@drhearne.com

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Name:____

Tel. No. ___________________________________ Date of Birth: ____________________________

Street Address: ____

City: ________________________________ State: ________________ Zip Code: ______________

The specific information that I wish to have released is:

☐ All Clinical Medical Records
☐ Other Records-Please list or circle (e.g. billing photographs OCT GDx visual fields):

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☐ Other records: (only last exam and glasses and/or contact lens prescription information, limited data)

This medical record may contain information about *physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.* Separate consent must be given before this information can be released.

☐ I **consent** to have the above information released.
☐ I **do not consent** to have the above information released.

Signature: ____Date: ________________
(Parent or Legal Guardian of a Minor)

This medical record may contain information concerning *HIV testing and /AIDS diagnosis or treatment.* Separate consent must be given to have this information released.

☐ I **consent** to have the above information released.
☐ I **do not consent** to have the above information released.

Signature: ____Date: ________________
(Parent or Legal Guardian of a Minor)

I understand that this authorization is valid for a 360-day period from the date that is signed. I may revoke this consent at any time through written notice.

Release Records To:
Hearne Vision Care
Dr. Kirk Hearne
29 E. Poplar Street
North Vernon, IN 47265
Phone: (812) 346-4646 Fax: (812) 352-6262 Email: records@drhearne.com