3640 MAIN STREET ● SUITE 205 ● SPRINGFIELD, MASSACHUSETTS 01107-1145 ● TEL. (413) 739-7367 ● FAX (413) 737-2686

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REQUEST & AUTHORIZATION TO RELEASE MEDICAL RECORDS

Please check one box only:

□ Please release all information concerning my medical records, including and “sensitive” or “privileged” information.

□ Please release all information concerning my medical records, except any “sensitive” or “privileged” information, specifically ____.

The above checked information is to be submitted for my care from (dates) ______________________

to (dates)__________________________________.

Send to person / organization listed below:

Person / Organization: Springfield Eye Associates, Inc.

Address: 3640 Main Street, Suite 205

City: Springfield State: MA Zip Code: 01107 Fax : 413-737-2686

RECORDS REQUESTED FROM (Office):

Office / Practice: ____

Address: ____

City: ________________________________ State: ______________________ Zip Code: __________________

Patient Name: __________________________________ Date of Birth: _____________________

Reason for Release: ____

Signed: ____ Date: ____________________
Patient / Parent / Guardian (please circle one)

Witnessed: ____ Date: ___________________

PLEASE NOTE: This authorization is valid for this request only and it must be accomplished within 30 (thirty) days from the date the authorization is received. Any request to revoke this authorization must be in person or in writing to protect your interests from interference.

Revised 6/2/2022