MEDICAL RECORDS RELEASE

J&JKIM VISION ASSOCIATES, LLC
ITALI EYE CARE
2625 Old Denton Road, Suite 422
Carrollton, TX, 75007

I _____________________________________ (patient's full name) authorize the above-named provider/entity to release the following designated medical information.

Patient's Date of Birth: _______________________________

Secure email: ______________________________________

Fax: ____

Information to be Released:

- ○ Copy of complete medical records including results of diagnostic testing
- ○ Copy of contact lens prescription(s)
- ○ Copy of spectacle lens prescription(s)
- ○ Other information____

Release Authorized to:

Practice Name: ____

Address: ____

City: _______________________________________, State: _________ Zip: ________________

Secure email: ____

Fax: ____

Via (choose one of the following):

○ Hard Copy ○ Fax ○ Web Portal

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I HAVE READ AND UNDERSTAND THAT BY SIGNING THIS FORM, I VOLUNTARILY AUTHORIZE J&JKIM VISION ASSOCIATES, LLC TO DISCLOSURE MY HEALTH INFORMATION TO THE ENTITY DESCRIBED IN THIS FORM. IF I AM SIGNING FOR A MINOR CHILD, I ATTEST I HAVE LEGAL AUTHORTY TO MAKE MEDICAL DESIGNATIONS FOR THE DESIGNATED MINOR.

I understand that I am permitted to revoke this authorization by sending a request in writing to J&JKIM VISION ASSOCIATES, LLC (ITALI EYE CARE) at the address above. I understand that if my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my personal health records. Finally, I understand that failure to sign/submit this authorization or its cancellation will not prevent me from receiving any treatment or benefits that I am entitled to receive.

____

PRINT Patient Name

____

PRINT Guardian's Name (if signed on behalf of the patient)

____ Date _____ / _____ / _________

Patient or Legally Authorized Individual's Aignature