



9890 Clayton Rd, Ste 200 St. Louis, MO 63124 PH: 314.395.9613 Fax: 314.395.9621

HIPAA RELEASE AND AUTHORIZATION

Patient's Name: _____ Date of Birth: _____

Address: _____ Social Security Number: _____

Medical Records. I hereby authorize **Complete Eye Care Inc** ("Releasor") to use or disclose the following:
(check one)

- Records relating to treatment dates from:** _____ to _____
- ALL Medical Records** for care at this facility or by this doctor. I request the release of my complete health record, which may or may not include protected health information (PHI) and electronic protected health information (ePHI) protected under HIPAA.

Restrictions - Medical information relating to diagnosis and treatment of alcohol or drug abuse, mental illness, STDs, or HIV/AIDS shall: (check one)

- Be Included.
 - NOT Be Included.

Recipient. My medical records shall be disclosed to the following individual or entity:

Name: _____ Contact: _____

Address: _____ Phone: _____

E-Mail: _____ Fax: _____

Purpose of Release: _____

I understand that signing this authorization is voluntary and that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon whether I sign this authorization.

I understand that I have the right to revoke this authorization at any time by writing to the Releasor, except where uses or disclosures have already been made based upon my original permission. To revoke this authorization, I must do so in writing and without my express revocation; this consent will automatically expire in 90 days from today's date.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original. Record requests may take up to 10 business days to process.

X

Patient or Personal Representative Signature

Date

Printed Name

Personal Representative Relationship to Patient

FEE SCHEDULE: State and federal laws specify a reasonable fee may be charged to offset the cost associated with the reproduction of records. The fee changes every February 1 (see Missouri section 191.227).

State of Mo. sets the base rate of \$30.32 plus \$.70 per page for 2026 for medical records.

For office use only:

Physician Authorization: _____ Date Sent: _____ By: _____