**Memphis Eye,**
**Cataract & Laser Center**
6485 Poplar Avenue
Memphis, TN 38119
Phone: (901) 767-3937
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MECA

# REQUEST FOR RELEASE OF MEDICAL RECORDS

James F. D. Freeman, M.D. John M. Freeman, M.D.
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Michael L. Wertheimer, M.D. Theresa K. Cassidy, O.D.

MECA Chart #_____

Patient Name:_____ DOB: _____

Address: _____ SS#: _____

_____

TO / FROM: MECA—Memphis Eye and Cataract Associates
6485 Poplar Avenue
Memphis, TN 38119

TO / FROM: _____
Physician/Organization Name

_____
Address, City, State, Zip

I hereby authorize the above to release or disclose all of my medical records including those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, sexually transmitted disease, or HIV/AIDS infection.

This request and authorization expires after 12 months from the date signed below unless otherwise indicated here:

_____(date cannot exceed one year)

This request and authorization applies to: _____Complete Medical Records _____Specific Dates of Treatment
_____Visual Fields _____Lab Results/Testing
_____Other _____

**If you DO NOT WANT certain portions of your medical records released, please initial the box for the information you do not want released.**

_____Substance Abuse _____Psychological/Psychiatric Treatment _____HIV/AIDS/STD
_____Other_____

I understand I have a right to revoke this authorization by written notification to the Privacy Officer, except to the extent it has acted in reliance thereon before notice of revocation. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure which may not be protected by federal confidentiality rules. I understand that I may request a copy of this authorization. I understand that I can refuse to sign this authorization and the above-named office may not condition treatment on my signing of this authorization.

_____ _____
Signature of Patient or Authorized Representative Date signed

_____
Relationship to Patient