Authorization to Release Confidential Information

Kesselman Eye Care
T: 305-850-3800 | F: 305-850-3801
kesselmaneyecare@gmail.com

Lenscrafters at Macy's
11605 Pines Blvd
Pembroke Pines, FL 33026
954-438-2427

Lenscrafters at Macy's
19535 Biscayne Blvd
Aventura, FL 33180
305-682-3493

Walmart Vision Center
19501 NW 27th Ave
Miami Gardens, FL 33056
305-662-6681

JCPenney Optical
2076 9th St N
Naples, FL 34102
239-430-9500

Patient's information

First name _____

Last name _____

Date of birth (month/day/year) _____/_____/_____

My relationship to the patient _____

Records to be released

- ▢ Spectacle prescriptions
- ▢ Contact lens prescriptions
- ▢ Charted notes
- ▢ Retinal images
- ▢ Other:

Pertinent dates (month/day/year)

From _____/_____/_____ To _____/_____/_____

Recipient of records

Name of individual or office _____

Address _____

Phone _____

Fax _____

E-mail _____

Method of release of records

- ▢ Print and pick-up
- ▢ E-mail
- ▢ Fax
- ▢ Other:

This authorization may be revoked at any time by providing a signed, written request.

In accordance with HIPAA guidelines, records should be released within 30 days of the date on the bottom of this form.

By signing this form, I expressly release Dr. Joseph Kesselman, Kesselman Eye Care, and all affiliated agents, from any liability relating to mishandling of protected health information as a result of compliance with this authorization. I certify that this request pertains either to myself or to a patient who is under my legal guardianship.

First name _____ Today's Date _____/_____/_____

Last name _____ Signature _____