MONTEREY BAY EYE CENTER

Leland H. Rosenblum, M.D.
Roger C. Husted, M.D.
Anna Shi, M.D.
Kasey Nakajima, O.D.

RECORDS RELEASE AUTHORITY

I, _____, hereby request that my records be released
(Patient or Guardian's Name, Date of Birth)

To / From Dr. _____

_____

_____

Phone: _____ Fax: _____

To / From:

Leland H. Rosenblum, M.D. / Roger C. Husted, M.D.

Anna Shi, M.D. / Kasey Nakajima, O.D.

21 Upper Ragsdale Drive, Suite # 200 Monterey, CA 93940
T: 831.372.1500 F: 831.655.6493

_____ _____
Date of Request Patient's Signature

_____ _____
MBEC Witness Address

_____ _____
Date City, State, Zip

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AUTHORIZATION TO RECEIVE/RELEASE HEALTH INFORMATION

We are required by the Federal Government's HIPAA Privacy Act to ask you review and answer the following question listed below.

Patient Name: _____

May we leave messages on voicemail that might contain detailed medical information?

☐ Yes ☐ No Home Phone: _____

☐ Yes ☐ No Mobile Phone: _____

May we contact you at your place of employment and leave a message?

☐ Yes ☐ No Work Phone: _____ Extension: _____

Do you have any person or family member that you authorize to receive and discuss information regarding your personal health information?

☐ Yes ☐ No Patient Initials: _____ If yes, please indicate below.

_____ _____
Name of Designated Person Relationship

_____ _____
Contact Phone Number Alternate Phone Number

Is this person your Power of Attorney for medical purposes? ☐ Yes ☐ No
If yes, please attach a copy of your Medical Power of Attorney document.

I hereby authorize _____ to obtain or release any and all pertinent information regarding medical care, as needed, to assist in my ongoing treatment to or from other healthcare providers, laboratories, radiology facilities or other institutions. This authorization remains in effect until revoked.

I have reviewed the aforementioned and provide my consent regarding any and all of the issues as stated above. I further understand that a copy of Monterey Bay Eye Center's HIPAA Privacy Notice will be provided upon my request.

_____ _____
Patient Signature Date

_____ MBEC Witness