Lanter EYECARE **Lanter EyeCare & Laser Surgery, PC**

10610 N Pennsylvania St. STE 102 Carmel, IN 46280	747 E County Line Rd. STE M Greenwood, IN 46143	5025 E 82nd St. STE 2300 Indianapolis, IN 46250

Main: 317-844-6269 **Fax: 317-815-7567** **indianapolis@lantereyecare.com**

AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION

Patient's Name						Date of Birth	
Address							
City		State		Zip		Phone	

Information to be released (dates of service): _____

	Physician Office Medical Records		Operative/Procedure Reports
	Copies of films/images		Billing Records
	Lab results/reports		Entire Record
	Other records (Specify record types)		

I authorize Lanter EyeCare & Laser Surgery, PC to release information to:	
I authorize Lanter EyeCare & Laser Surgery, PC to obtain information from:	

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, to ***include alcohol, drug abuse, communicable disease including HIV status, and/or psychiatric diagnoses*** compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

I agree to the release of my medical or billing records containing the sensitive information listed above. ☐ **Yes** ☐ **No**

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. This authorization will automatically expire 60 days after the date of signature below (except as indicated above), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, as stated in the Notice of Privacy Practices, except where the facility has already made disclosures in reliance upon my prior authorization. Lanter EyeCare records may include records that it received from other organizations. If these records have been used by LEC, and filed in the record LEC maintains about you, these records may be released with your LEC records.

I understand that it will take up to 10 business days to retrieve, copy/print, and make my records available for distribution and it is my responsibility to allow adequate notice as to the needs and timeliness of my health records.

Fees may be charged in accordance with IN Statue 760 IAC 1-71-3 and Federal Rule 45 C.F.R. 164.524
$20 labor fee (includes first 10 pages), $0.50 per page (pg 11-50), $0.25 per page (pg 51 & higher), $10 rush fee if records due within 2 days, actual mailing costs.
Amount due $ _____

Signature of Patient or Personal Representative	Date
Name of Personal Representative (please print)	Description of representative's authority to act for the patient