Authorization for Release of Medical Records

I hereby authorize the release of information from the medical record of:

Patient name:____ Date of Birth:________________

Social Security Number:________________________________ Tel #:______________________

Information Released to:

Dr. Christopher Sween Optometrist Inc.
4589 Kapolei Pkwy
Kapolei, Hi 96707
Office/ (808) 674-3913
Fax/ (808) 674-3914

From:

____
____
____
____
____

Please Release the following:

_______ Date of last exam
_______ Last Contact lens Rx
_______ PreTx IOP
_______ Ocular findings
_______ Ocular Meds/Date of last Rx
_______ Last Spec. Rx
_______ Last IOP
_______ Last VA
_______ Medical findings

Purpose of Need for Disclosure: To provide continuity of care to above listed patient with Dr. Chris Sween.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken in reliance on it. This consent will expire 90 days after the date of my signature unless otherwise specified

____ ____________________
Signature of Patient or Legal Representative Date

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT

I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries.

I will not hold Dr. Christopher Sween Optometrist Inc. liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

____ ____________________
Signature of Patient or Legal Representative Date