California Eye Associates
*Eye Surgeons & Physicians*

iAesthetica

Katerina Kurteeva MD

# Medical Records Request

The authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: *This authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by that Lanterman-Petris – Short Act.*

AUTHORIZATION

Patient Name: _____ Account#: _____DOB_____

Street Address: _____

City/State/Zip Code: _____ Phone#: _____

**I hereby authorize, _____ To release all medical and/or Ophthalmic records of the patient named above to:**

_____

_____

_____

This request and authorization includes, but is not limited to:

- All examination and progress notes, including prescribed medications.
- All current and previous glasses and contact lens specifications.
- Any diagnosis, treatment, prognosis, recommended and other patient data
- All visual fields, diagnostic test results, photographs, and surgery operation notes.
- Other (specify)_____

_____ _____

Patients Name (PRINT) Date

_____ _____

Signature of Patient *or legal/personal representative* Relationship *if other than patient*