Sedgewick Eye Associates, P.C.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient's Name: _____

Date of Birth: _____ Tel. No.: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

The specific information that I wish to have released is:

☐ All Clinical Medical Records

☐ Other Records - Please list (e.g. billing, angiograms, photographs, etc.):

_____

_____

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.** Separate consent must be given before this information can be released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Signature: _____ Date: _____

(Parent or Legal Guardian of Minor)

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment.** Separate consent must be given to have this information released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Signature: _____ Date: _____

(Parent or Legal Guardian of Minor)

I understand that this authorization is valid for a _____ day period from the date that is signed. I may revoke this consent at any time through written notice.

Release Records to:

Name: Dr. Jeffrey Sedgewick, M.D. **Tel. No.** 703-723-1981 **Fax:** 703-723-3937

Street Address: 44121 Harry Byrd Highway, #175

City: Ashburn **State:** VA **Zip Code:** 20147