# ROBERT M. STERN, M.D. INC.

## AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

Patient Name:_______________________________ DOB: _____________ Last 4 digits of SS __________

Address: ____________________________________________________________________________
City State Zip Code

Telephone #: _______________________________ Other #: ___________________________________

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**❑ TO RELEASE MEDICAL RECORDS**

I hereby authorize Robert M. Stern, M.D., Inc. to release health information indicated below that is contained in my patient records to:

Physician Name: ___________________________________________________________

Address:_________________________________________________________________

Phone: _______________________________ Fax: ______________________________

**❑ TO OBTAIN MEDICAL RECORDS**

I hereby authorize the physician listed below to release my patient records to Robert M. Stern, M.D., Inc.

Physician Name: ___________________________________________________________

Address:_________________________________________________________________

Phone: _______________________________ Fax: ______________________________

Please be specific what information you permit to be disclosed:

_____________________________________________________________________________

This protected health information is being disclosed for the following purposes:

_____________________________________________________________________________

This authorization shall be in force and effect until _____________________________________________
SPECIFY DATE OR EVENT THAT RELATES TO THE PATIENT OR THE PURPOSE OF THE USE OR DISCLOSURE

at which time this authorization to disclose protected health information expires.

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to the office of **Robert M. Stern, M.D., Inc. 29101 Health Campus Drive, Suite 340 Westlake, Ohio 44145 or www.sterneyes.com.**

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

_____________________________________________ ______________________________
**Signature of Patient or Personal Representative** **Date**

_____________________________________________ ______________________________
**Print Name of Personal Representative** **Relationship to patient**