SOUTH MICHIGAN OPHTHALMOLOGY

Records Release Form

The office of South Michigan Ophthalmology will provide your records to you no later than 30 calendar days from receiving this completed this form. Please be sure to sign this form, as unsigned requests cannot be processed. To cover the costs of copying, in accordance with the Medical Records Access Act – Act 47 of 2004, section 333.26269, the following fees apply and must be paid before records will be released:

Per page for pages 1-20	Per page for pages 21-50	Per page for pages 51+	Postage (if mailed)
$1.00	$0.50	$0.20	Will vary

If you request an explanation or summary of your chart to be prepared by the physician, you will be charged a fee of $30.00

Patient's Name: _____ Birth Date: _____
Patient's Address: _____
_____
_____

I hereby agree to the above listed fees and authorize the release of:

- ◯ ALL MEDICAL RECORDS
- ◯ MEDICAL RECORDS FROM _____ THROUGH _____
- ◯ SPECIFIC ITEMS FROM MY MEDICAL RECORDS (PLEASE LIST):

_____

or copies of such from South Michigan Ophthalmology:

Darren Hathaway, M.D. * Shannon Martin, M.D.
830 W. Michigan Ave., Marshall MI 49068
350 Marshall St., Coldwater, MI 49036

269-781-9822 (Marshall) * 800-323-3622 (Coldwater) * 269-781-9839 (Fax)

and request that they be transferred to:

Doctor/Practice Name: _____
Phone #: _____ Fax #: _____
Address: _____
_____
_____

_____ _____
Patient or Authorized Representative Name (please print) Relationship to patient

_____ _____
Patient or Authorized Representative Signature Date