

# ACCURATE OPHTHALMOLOGY

## AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

*Please print*

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|                |                  |                       |
|----------------|------------------|-----------------------|
| Patient Name   | Other Last Names |                       |
| Date of birth  | Phone Number     | Email Address         |
| Street Address |                  | City, State, Zip code |

Transfer of care is required due to the closing of my physician's office. Therefore, I hereby authorize

**Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103,**

on behalf of **Accurate Ophthalmology, 2627C Hylan Blvd, Staten Island, NY 10306** to execute one of the following:

***Please select one of the following delivery options:***

- Secure HIPAA approved electronic transfer to patient.  
*List your email address here* \_\_\_\_\_
- Pick up disc, in person, at **Morgan Records, 159 Frontage Road, Manchester, NH 03103**. Once the chart is processed, we will contact you to set up pick up time.
- Disc mailed to home or physician. There will be a **\$10 shipping charge prior to mailing**. We mail USPS Certified Return Receipt. List address here:  
\_\_\_\_\_

I, \_\_\_\_\_, am the patient or legal guardian who has authorization to release the above records. Any facsimile, copy, or photocopy of this release will be valid for 90 days and shall authorize you to forward my medical records. This form gives you permission to share my private information obtained from this facility. Only records from this facility can be legally released. Any records from other physicians must be obtained from them directly.

**Please note: A \$25 records management fee is requested to process and deliver your medical records.**

### Payment Options:

- **CREDIT CARD** – visit our website at [MorganRecordsManagement.com](http://MorganRecordsManagement.com)-> Medical Records tab-> Request My Records to use our online form
- **CHECK** - please mail your completed form with an attached check or money order made payable to Morgan Records Management LLC, to 159 Frontage Rd, Manchester, NH 03103.

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|-------------------------------------|------|
| Patient or Legal Guardian Signature | Date |
|-------------------------------------|------|

Your completed authorization form may be faxed to 603-606-1126, emailed to [Medical@MorganRM.com](mailto:Medical@MorganRM.com), or mailed to Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103.