Patient Request for Medical Records Transfer
Authorization for release of Protected Health Information
(Multiple family members/children)

Patient(s) Information

Last Name: _____ **First Name**: _____ **MI**: _____ **Date of Birth**: _____
Last Name: _____ **First Name**: _____ **MI**: _____ **Date of Birth**: _____
Last Name: _____ **First Name**: _____ **MI**: _____ **Date of Birth**: _____
Last Name: _____ **First Name**: _____ **MI**: _____ **Date of Birth**: _____
Last Name: _____ **First Name**: _____ **MI**: _____ **Date of Birth**: _____
Last Name: _____ **First Name**: _____ **MI**: _____ **Date of Birth**: _____
Last Name: _____ **First Name**: _____ **MI**: _____ **Date of Birth**: _____

Address:_____ **City**:_____ **State**: _____ **Zip**: _____

I have been a patient of your office/facility (or am the patient's authorized representative) and I understand that Bloom Eye Care has legally protected health information about me (or the person I represent) that I wish to transfer

I, _____ **hereby authorize** **Provider:** Bloom Eye Care,PLLC
Previous Address: 250 W 65th St, Loveland, CO 80538
Email: drlancebloom@bloomeyecare.com

to release the named patient records to:

Provider you want to receive your records:

Practice Name:_____ **Provider Name**: _____
Address: _____ **City**:_____ **State**: _____ **Zip**: _____
Phone :_____ **Fax**: _____ **Email**:_____

For treatment date from _____ (mo/yr) to _____ (mo/yr)

The purpose of the release of this information is:

☐ Transfer of Care
☐ Other (specify)_____

- By signing below, I acknowledge that: I may revoke this authorization in writing, but it will not affect disclosures/transfers already in progress made with this authorization
- I can receive a copy of this authorization upon request
- A photocopy or scanned image of this authorization may be used in lieu of the original
- If health information is disclosed to a person who is not covered by federal or state confidentiality laws, there is potential for this information to be subject to re-disclosure and no longer be protected by these laws
- I have read and understand this Authorization, have had the opportunity to have my questions answered, have signed this Authorization freely and have received a copy of this Authorization.
- Please not, this Authorization expires one (1 year after the date of signature unless otherwise specified

Signature: _____ Date: _____

If signed by a personal representative of the patient, please print name and relationship to patient:

Name: _____ Relationship: _____

If not the legal parent, please attach a copy of documentation of personal representation, e.g. Power of Attorney, Legal Gaurdianship