Dr. David E. Scott, O.D.
6004 SW 9th Street
Des Moines, IA 50315
Phone: (515)287-0820
Fax: (515)287-0938
Email: fehreceptionist@qwestoffice.net

REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient's Name: ______________________________________ Birthdate: _________________
Previous Name: (if applicable) ____
Address: ____
City: _________________________________State:_____________ Zip: ___________________

This will authorize:

Doctor's Name and Facility: ____
Address: ____
City: _________________________________State:_____________ Zip: ___________________

To release the information listed below to Dr. David E. Scott, O.D.

Medical and Exam information
Glasses Prescription
Contact Lens Prescription

THIS WILL AUTHORIZE FOR RELEASE OF INFORMATION PROTECTED BY STATE OR FEDERAL LAW. I SPECIFICALLY AUTHORIZE THE RELEASE OF DATA AND INFORMATION RELATING TO:

Circle One:

Yes or No Substance abuse (alcohol/drug use)
Yes or No Mental Health/depression includes (psychological testing)
Yes or No HIV related information/AIDS testing

This authorization will atomically expire one year from the date of signature or until __________, 20______. I understand that I may revoke this consent at any time by notifying the above named provider of information. Any release of information made prior to my revocation, is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. RESTRICTIONS: This authorization is being given with the understanding that the receiver may not further use or disclose the medical information unless another authorization is obtained from me or unless such use of discloser is specifically required or permitted by law.

Signature of Patient or legal guardian: ____
Relationship if not patient: __________________________________Date: ________________

For Office Use Only: Faxed by: _________________ Date: ____________Time: ________________