AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS TO BOSTONSIGHT® NETWORK CLINICS

Please note: BostonSight Network Clinics are independent of BostonSight. Fees, policies, procedures, and financial assistance programs vary from clinic to clinic.

Patient Name :________________________________ **Date of Birth:** ____________

Address:____
Street City State Zip

Phone Number: ________________________ **E-Mail:** ___________________________

I hereby authorize BostonSight to release protected health information, including copies of the medical record of the above named patient, to the following person or facility:

____

Name of Person or Facility

Method of Delivery: **E-Mail** **Fax** **Mail**

____

Address **City** **State** **Zip**

Phone: (_____) _______ - ____________ **Fax: (______) _______ - _______________**

E-Mail:____

____ ____________________

Signature of Patient or Authorized Representative **Date**

____ ____________________

Printed Name of Patient or Authorized Representative **Relationship to Patient**

For Office Use Only

____ **OD/MD**

BostonSight doctor authorizing transfer

____ ____________________

Signature of Doctor **Date**

Date Sent: ________________________
By Whom: ________________________
Dates Sent: _________________________ **to** ______________________________

Rev. 04/19/2016

AUTHORIZATION FOR RELEASE OF BOSTONSIGHT® PROSE DEVICE MANUFACTURING HISTORY TO AN ADDITIONAL BOSTONSIGHT CLINIC

Please note: This authorization is required for sharing manufacturing data that is not typically included in a clinic's Medical Record.

Patient's Name:___________________________________ Date of Birth:___________________________

☐ *Check if your last name has changed since last appointment. (Prior Name:______________________________________)*

Address: ____
Street City State Zip

Phone Number: _______________________________ Email:________________________________

I hereby authorize the BostonSight Manufacturing Lab to allow access to my BostonSight PROSE device manufacturing history and my associated PHI to the following BostonSight PROSE Clinic:

- ☐ Alkek Eye Center/ Baylor (23)
- ☐ Bascom Palmer Eye Institute (37)
- ☐ BostonSight, Needham (9)
- ☐ Brooke Army Medical Center (21)
- ☐ Flaum Eye Institute (102)
- ☐ Kellogg Eye Center (28)
- ☐ Northwell (35)
- ☐ University of California, San Francisco (39)
- ☐ University of Illinois at Chicago (31)
- ☐ USC Roski Eye Institute (19)
- ☐ Weill Cornell Eye Associates (30)
- ☐ Wilmer Eye Institute – Baltimore (36)
- ☐ Wilmer Eye Institute – Bethesda (41)

____
Signature of Patient or Authorized Representative Date

____
Printed Name of Authorized Representative Relationship to Patient

For Office Use Only

☐ COM Verified ☐ DTF Linking Completed By: ________________________ Date:_____________