Oculoplastics, LLC
Medical Records Release

(Name of Patient) _____ (Birthdate) _____

(Street Address) _____ (City, State, ZIP Code) _____

Authorizes Release of Records To:

(Name of Physician) _____

(Name of Health Care Facility) _____

(Street Address) _____

(City, State, ZIP Code _____

Release From:
Oculoplastics, LLC
Raymond G. Magauran, M.D.
175 Dwight Road
Longmeadow, MA 01106

List other facilities records to be included when releasing for the purpose of continuing medical care:

_____

For the Following Dates: _____

In compliance with state statutes which require special permission to release otherwise privileged information, please release records pertaining to:

- ☐ Mental health
- ☐ Developmental disabilities
- ☐ Alcoholism
- ☐ AIDS test results
- ☐ AIDS-related disease diagnosis
- ☐ Drug abuse
- ☐ Other

Purpose or need for disclosure: (check applicable categories)

- ☐ Further medical care
- ☐ Application for insurance
- ☐ Disability determination
- ☐ Payment of insurance claim
- ☐ Vocational rehabilitation evaluation
- ☐ Legal investigation
- ☐ Personal
- ☐ Other

I understand that this authorization shall be valid for one (1) year unless otherwise stated below or revoked through written notice to Medical Records. _____
(Alternate date if not one (1) year)

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

Signature of Patient _____ Date _____
(If signed by person other than patient, state relationship and authorization to do so)

(Authorized signature) _____ (Relationship) _____

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority: ☐ Legal ☐ Legal guardian ☐ Next of kin of deceased

Complete and send this form via e-mail to **queries@oculoplasticsllc.com**
to transfer your medical records