Dr. Rob Gerowitz
Optometrist - Orthokeratologist
Mission: Myopia Control, P.C.
2723 Sheridan Rd, Suite C(c/o The Inn on Sheridan) Zion IL 60099

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION RECORDS

THIS AUTHORIZATION IS BEING COMPLETED BY:_____PATIENT. _____LEGAL REPRESENTATIVE
On_____/_____/_____

Patient Name:_____Date of Birth:_____/_____/_____

Patient Address: _____
Location of Records: Eyecare of Palatine, 4880 Euclid Ave #101, Palatine IL 60067
(FAX your request to: 847-478-9095 or Email your request to: ecsofil1454@aegvision.com)

OR Other location: _____
As the patient or patient's legal representative, I authorize the information requested to be released to:
Dr. Rob Gerowitz, Optometrist – Orthokeratologist, Mission: Myopia Control, P.C.
2723 Sheridan Rd, Suite C, c/o The Inn on Sheridan, Zion IL 60099
Phone 224-338-6692 / FAX 224-306-2848 / robgerowitz@gmail.com

This request is for **ALL RECORDS ON FILE FOR THE PERIOD OF JANUARY 1, 2023 TO PRESENT** and shall be delivered via:
_____FAX to 224-306-2848
_____Secure email
_____USPS Mail delivery
_____In-person pick up by either the patient or legal representative listed above

The records on file FOR THE PERIOD OF JANUARY 1, 2023 TO PRESENT requested above shall include the following for Continuation of Care:
_____ ALL COMPREHENSIVE EXAM ENCOUNTERS
_____ PROGRESS CHECK UPS; INCLUDING BUT NOT LIMITED TO ORTHOK /MYOPIA MANAGEMENT, STANDARD CONTACT LENSES, SPECIALTY CONTACT LENSES
_____BASELINE AND MOST RECENT CORNEAL TOPOGRAPHIES
_____MOST RECENT RETINAL IMAGES
_____BASELINE AND MOST RECENT OCT IMAGING
_____ALL MEDICAL ENCOUNTERS

On behalf of the patient or legal representative:

1. I understand I may revoke this authorization at any time by notifying the practice of request in writing and it will not affect any release of information prior to such request
2. The practice of request will not place conditions on treatment, payment, or eligibility for benefits on the basis of my signature below
3. I understand the information requested above is protected by HIPAA
4. I understand this authorization is valid for a period of one year from the above date of request
5. I understand I shall receive a copy of this signed form if requested
6. I understand this authorization relates to all records designated above. My signature gives my express consent to release this information.

Signature of Patient or Legal Representative _____

Name of Patient or Legal Representative _____

Relationship to Patient_____or Self _____