AFFLECK MD
Medical Surgical Optical Laser
EYE CARE
2900 Valencia Drive, Idaho Falls ID 83404

Aaron J. Affleck, M.D.
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Release of Information

Section A: Patient information

Patient's Name: _____ Today's Date: _____

Patient's Phone: _____ Date of Birth: _____ Last 4 digit SSN: _____

Address 1: _____ Address 2: _____

City: _____ State: _____ Zip: _____

Section B: Recipient/delivery of Information (mark one "to" and one "from")

☐ To (recipient of information)
☐ From (delivery of information)

Affleck, MD Eye Care
2900 Valencia Drive
Idaho Falls, ID,83404
Fax: 208-523-7272
Office: 208-523-6868

☐ To (recipient of information)
☐ From (delivery of information)

Name _____
Address 1: _____
Address 2: _____
City, State & Zip: _____
Fax: _____
Office: _____

Section C: Information Released

Dates of information: _____

☐ Complete records

☐ The following test(s): _____

☐ Other: _____

Section D: Payment/Signature

An advanced payment of $6.50 for release of records is required. This fee includes faxing services. To mail a charge of 69¢/1-30 page & 53¢/31+ page is added. No fee is charged if transfer records is due to a referral by Dr. Affleck,

Authorized Signature: I understand that the information disclosed may contain matter that is protected by Federal and State laws, including information that may relate to ALCOHOL AND DRUG ABUSE, PSYCHIATRIC DISORDERS AND TREATMENT, AIDS, and/or HIV TESTING and/or other SEXUALLY TRANSMITTED DISEASES. I specifically consent to release and disclosure of this information, including transmission of my medical records via a facsimile (FAX) machine. Subsequent transfer of the records or disclosure of their contents is prohibited without my specific consent.

_____

Signature of patient or authorized representative Date Signed

_____

Relationship if other than patient