John C. Hersey, OD
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Authorization to Release Health Care Information

Patient Name: ____ **DOB:** ____________________

Hereby authorizes: ____

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To disclose my health care information to:

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I understand that the originals of all records generated while I was a patient of this practice will be kept and, upon request, I will be provided a copy of them. I also understand to insure confidentiality that I may be asked to show identification, including a picture, such as a driver's license. I realize this is for my protection and to help insure my confidentiality. Further, I understand that I may be asked to pay a reasonable charge for copying my records and that this amount must be paid prior to the records being released.

The reason I am requesting these records is:

- ☐ Transfer of care
- ☐ For a consultant/specialist appointment
- ☐ Personal records
- ☐ Other: ____

Patient's Name *(print)*: ____ Date: ________________

Patient's Signature *(parent, if minor)*: ____

Witness: ____

Hermon Office
(207) 848-5220
2350 Rte. 2
Hermon, ME 04401

Palmyra Office
(207) 355-3937
1573 Main St. | Suite 1
Palmyra, ME 04965

Bangor Mall Eye Assoc.
(207) 262-7192
663 Stillwater Ave. | Suite 1132A
Bangor, ME 04401

Winterport Family Eyecare
(207) 223-5555
14 Parsonage St.
Winterport, ME 04496