JOSEPH & SWAN
EYE CENTER

PRIMARY & CORNEA EYE CARE
IN ACADIANA

214 Southcity Pkwy
Lafayette, LA 70503
Phone: 337.981.6430
Fax: 337.981.9134
www.bohnjosepheyemd.org

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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I hereby authorize _____to release copies of the below specified medical records and information regarding treatment and examination rendered to me to:

Dr. Jonathan M. Joseph and Dr. Kevin R. Swan
Bohn, Joseph & Swan Eye Center
609 Guilbeau Road
Lafayette, LA 70506
Phone: 337-981-6430 Fax: 337-981-9134

☐ Records for these dates of service: From_____ to _____.

☐ All medical records

☐ Other _____

The authorized copies of my medical records are to be:

☐ Picked up by the above referenced person

☐ Mailed to the above referenced person at the address indicated

☐ Faxed to the above referenced person at the fax number indicated

A photocopy of this authorization is to be accepted with the same authority as this original.

This authorization for release of medical records expires on: _____

I understand that I have the right to revoke this authorization at any time by contacting this office with a verbal statement of revocation followed by written notice within three business days.

Date: _____

Patient Signature: _____
(Or Person Legally Authorized To Sign on Behalf of Patient)

Print Name:_____ MRN:_____

Patient Address:_____ Last Four Digits of SSN: _____

_____ Patient Date of Birth:_____

_____