Loman Eye Care
630 3rd Ave S.W. Suite 100
Carmel, IN 46032
Phone: 317-844-7474
Fax: 317-819-0073

Patient Information: Print Name: _____ Date of Birth: _____

Please Release My Healthcare Information From:
Name of Facility/Provider:
_____
Address:
_____
City, State, and Zip:
_____

Please Send My Healthcare Information To:
Loman Eye Care

630 3rd Ave S.W. Suite 100

Carmel, IN 46032

Information To Be Released

- ❑ The Most recent 2 Years of pertinent information (charts notes and special tests)
- ❑ All Medical Records
- ❑ Specific Information (please specify)

Purpose For Which Disclosure is Being Made:

- ❑ Sharing with other healthcare providers
- ❑ Legal Investigation
- ❑ I am transferring my care to another provider
- ❑ Personal Use
- ❑ Other: _____

My Rights

I understand that I do not have to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing. To view the process for revoking this authorization, please read the Privacy Notice posted at the facility where the information is being released. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.

Signature: _____

Date: _____