College of Optometry
Center for Eye Care
www.optometry.umsl.edu

UMSL Optometry
University of Missouri–St. Louis

University Eye Center
7840 Natural Bridge Road
Patient Care Center
St. Louis, MO 63121
(314) 516-5131
(314) 516-5507 FAX
(314) 516-6405 Medical Records Fax
(all offices)

Lindell Eye Center
3940 Lindell Blvd.
St. Louis, MO 63108
(314) 516-5016
(314) 535-4741 FAX

East St. Louis Eye Center
601 James R. Thompson
Bldg. D-Ste. 2030
East St. Louis, IL 62201
(618) 274-0169
(618) 274-0781 FAX

TPO Authorization For Release of Medical Records - II

☒ I, _____, _____, hereby authorize
(Name of Patient) **(Date of Birth)**
the UMSL Center for Eye Care to release from my medical record the information checked below:

❑ Examination ❑ Lab Reports ❑ Photographs
❑ Consultant Reports ❑ Sonograms/Visual Fields ❑ Insurance Claim

❑ Complete Medical Record (purpose): _____
❑ Other *(please specify)*: _____ Date*(s)* of treatment*(s)*: _____
Unless otherwise provided by law, records and information concerning testing for presence of HIV-antibodies and/or treatment of AIDS, will be released only if I indicate my specific consent by signing my name:

_____
(Signature)

Purpose or need for disclosure *(please check applicable categories)*:
❑ Further Vision/Medical Care ❑ Disability Determination ❑ Other _____

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that the information being disclosed may be subject to re-disclosure by the recipient and no longer protected by law. I further understand that I do not need to sign this authorization in order to receive medical care and treatment from this Provider.

Information Source: _____
Name, Group, or Company

Please write in where you would like the record sent to, here: →

Sign down here: ↓

_____
Address

_____
Phone, Fax, or E-mail Address (with the understanding that we cannot guarantee the privacy of transactions sent via electronic methods. Documents sent via e-mail will be delivered via UM Secure TransmIT dropbox system, and will only be available for 7 days after sending)

_____
(Signature of Patient) (Date)

_____
(Signature of legal representative if patient is a minor, legally incompetent or unable to sign) (Date) (Relationship to Patient)

This authorization expires six months from the date of signature. A photocopy of the authorization shall be as valid as the original

Copies of the most current primary care exam and a summary of a most current Eye Health Management, Pediatric or Contact Lens exam will be available at no charge. **Any additional records will be subject to fees as permitted by applicable state and federal laws and regulations.**