Ophthalmic Consultants of Boston will be happy to provide a copy of your medical records to any individual or organization with a signed request and consent from you or your guardian specifying to whom the record should be released.

There is a $15.00 processing fee for the copying of medical records in excess of the last two visits. If your records are being sent to another physician's office, there will be no fee. As noted in the General Laws of Massachusetts (www.mass.gov):

There are additional fees for copies of photographs of the eyes. The fees are as follows:

- Photographic slide copies are $4.00 per slide
- Polaroid print copies are $8.00 per photograph
- Digital Angiogram are $5.00 per page
- Corneal Topography/Pentacam/OCT are $2.00 per page

There is a three-week turnaround time for the processing of photographs. Photograph requests may be sent separately from all other copies of records.

Full payment for copying services is required before release of the medical records. Please make checks or money orders payable to ***Ophthalmic Consultants of Boston***, and forward, along with the completed release form (attached), to:

50 Staniford Street
Suite 600
Boston, MA 02114

Attn: Keeper of the Records

Upon receipt of your check and release form, your medical record will be mailed to the person indicated on the signed release form.

Sincerely,
Keeper of Records

PLEASE FAX THIS SIGNED & COMPLETED FORM TO 617-573-1099

OR

BY MAIL TO:
OPHTHALMIC CONSULTANTS OF BOSTON
50 STANIFORD STREET, SUITE 600
BOSTON, MA 02114
ATTENTION: MEDICAL RECORDS

We will provide copies of your copied records sent directly to your physician free of charge. Please note that re-prints of photographs will incur additional charges.

MEDICAL RECORDS RELEASE AUTHORIZATION

(rev 10/30/13)

☐ I hereby authorize my medical records be released to:

Ophthalmic Consultants of Boston (OCB)
50 Staniford Street, Suite 600
Boston, MA 02114
(617) 367-4800
Fax: (617) 573-1099

☐ I hereby authorize Ophthalmic Consultants of Boston (OCB) to release my medical records to:

Name of Doctor or Eye Practice
_____

Street Address _____

City/State _____

Information to be released:

☐ Last Two Visits ☐ Specific Dates: _____ to _____
☐ Last 12 months of Visits ☐ All Service Dates
☐ Last 5 years of Visits

Reason for medical records release:

☐ Second Opinion ☐ Dissatisfied with eye care provider
☐ Moving out of the area ☐ Dissatisfied with eye care practice
☐ Changing doctors (If for another doctor appointment, what is the date of the scheduled appointment? _____)
☐ Returning to original provider ☐ Winter MD

Patient Name (print) _____

Patient DOB: _____

Patient Signature:_____Date: _____

Witness to Signature:_____ Date:_____