Joliet EyeCare Assoc.
301 Springfield Ave
Joliet IL 60435

Ph: 815-744-3222
Fax: 815-744-3519
www.JolietEyeCare.com

Date: _____/_____/______

Last Name: ______________________________ **First Name:** _________________________ **DOB:** _____/_____/______

☐ **Release of Records to Joliet EyeCare Associates**

I, ___________________________, request the release of my exam records. Please fax the last 1-2 years of my records and or any other pertinent information regarding my care to Dr. Tahir. If Dr. Tahir needs more information he may call you personally.

RELEASE TO:

Joliet EyeCare Associates
301 Springfield Ave
Joliet IL 60435

Phone: 815-744-3222
Fax: 815-744-3519

FROM:

____

____

____

☐ **Release of Records to Another Office from Joliet EyeCare Associates**

Last Exam or a "Summary of your Exam plus any pertinent information," will be sent to the Eye Doctor listed below via Fax, for free. In most cases this information is sufficient for your eye healthcare. If further information is requested or the full release of your records is required, there is a $21.00 fee and up to a ROROR3 day requirement.

HIPAA and the IL legislations allow fees for the release of your records. If you have any questions please see the HIPAA law or visit www.isms.org or http://www.ilga.gov/legislation/

I, __________________________, request the release of my exam records transferred to:

TRANSFER MY RECOREDS TO (MUST BE FILLED IN FULL):

Name of Facility: ____

Ph:___ _____________________________ Fax: _______________________________

Address: ____ City:_____________________ St:_______ Zip:_____________

Printed Name: ____

Signature: ____ **Date:** ______________________