TRANSFER OF RECORDS

Complete this form only if you want your records sent to the receiving optometry office identified below.

Patient full name: _____ Date of birth: _____
Address:_____
_____

Phone: _____ Email:_____

Receiving optometry office —
Optometrist/provider: David Bloomberg,OD
Practice name: Poway Vision Care
Street address: 13035 Pomerado Rd, Ste C
City/State/ZIP: Poway, CA 92064
Phone: 858-674-1276 or 858-486-7609
Email: northcountyoptometry@gmail.com or info@powayvisioncare.com

Authorization
I authorize _Mitchell S Shulkin,OD aka North County Optometry, to disclose and transfer my optometric records to the receiving optometrist/practice identified above.
Records authorized (check one):
☐ My complete optometric record
☐ Records from _____ through _____
☐ Other (describe): _____
Purpose (optional): ☐ Continuity of care ☐ At my request ☐ Other: _____

I understand that: (1) signing this form is voluntary; (2) I may choose any provider and am not required to receive care from the receiving office; (3) I may request a copy of my records for myself or authorize transfer to another provider; (4) this authorization applies only to the provider/practice identified above and the records scope selected; (5) once disclosed, the information may be redisclosed by the recipient and may no longer be protected by the same federal privacy rules; (6) I may revoke this authorization in writing, except to the extent action has already been taken in reliance on it;

Patient or personal representative signature: _____

Printed name: _____ Date: _____
If representative, authority/relationship: _____

Please return this form by mail or a secure electronic signing application. You may choose to email us, but email may not be secure so please do not disclose any health information.

Records custodian use only: Identity/authority verified ☐ Date received: _____
Date sent: _____ Method: _____ Recipient verified: _____