Dear Provider,

The patient named below is new to our eye care practice and has identified you as a provider involved in his/her care.

Patient Name Date of Birth

To help us coordinate care as accurately as possible, we’d appreciate if you could **forward an electronic summary file from your EHR** to the Direct messaging address below. As you know, Direct messaging of electronic files allows our EHRs to communicate securely with one another and, in turn, build reliable information into our records.

**Please forward the electronic file to XXXX.XXXX@direct.revolutionehr.com.** < ENTER YOUR DIRECT ADDRESS HERE BEFORE PRINTING

**Patient Authorization**

**Authorization:** I voluntarily consent to and authorize the health care provider or practice named below to disclose my health information to the recipient identified below during the term of this authorization

Provider or Practice Name

**Recipient:** I authorize my health care information to be released to the following recipient:

PRACTICE NAME < ENTER YOUR PRACTICE NAME HERE BEFORE PRINTING

PRACTICE ADDRESS < ENTER YOUR ADDRESS HERE BEFORE PRINTING

XXXX.XXXX@direct.revolutionehr.com < ENTER YOUR DIRECT ADDRESS HERE BEFORE PRINTING

**Purpose:** I authorize the release of my health information to assist in coordination of my care

**Information to be disclosed:** An **electronic summary file from the EHR** containingall applicable health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me

**Term:** I understand that this authorization will remain in effect until the authorized provider or practice fulfills this request

Patient or Representative Signature Date

Thank you for your assistance and we look forward to collaborating in the care of this patient.