PATIENT AUTHORIZATION FOR THE DISCLOSURE OF PROTECTED HEALTH INFORMATION

*Please complete all items. An incomplete request may result in delay of release of records

_____ _____
Name of Patient Date of Birth

_____
Street Address City State Zip Phone

_____
Maiden name or other name used for records

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I HEREBY AUTHORIZE:

_____ Phone#_____
Name of person or place records are requested from

_____ Fax#_____
Address of person or place records are requested from

TO RELEASE TO:

_____ Phone#_____
Name of person or place records are to be sent to

_____ Fax#_____
Address of person or place records are to be sent to

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Method of Medical Records Delivery: (Mark one) ( ) Pick up records ( ) Mail Records ( ) Fax Records

THE FOLLOWING INFORMATION FROM MY MEDICAL RECORDS:

( ) Last Exam; Including most recent tests (VF, OCT, PACHY, etc)

( ) Records from time period _____ to _____

( ) Complete Medical History

Expiration of the Authorization: (Please mark one)

( ) 90 days after signature date **( )** No Expiration **( )** On this date_____

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I Understand that after the custodian of records discloses my health information, it may no longer be protected by federal laws. I understand the information released in response to this authorization may be re-disclosed to other parties. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below, I represent and warranty that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclose of this protected health information.

_____ _____
Patient Signature (Parent or Legal representative, if applicable) **Date**

_____
Print Name