Physicians & Surgeons
Ophthalmology

Diplomates American
Board of Ophthalmology

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Authorization to Disclose Protected Health Information from The Eye Clinic, P.C.

COMPLETE ALL AREAS OF THIS FORM.

Patient: ____________________

Nickname/Maiden Name/Other: ____________________

Social Security: ____________________ Date of Birth: ____________________

Telephone Number(s): ____________________

Address: ____________________

I authorize The Eye Clinic, P.C. to release the following information to the below named healthcare provider/clinic for the purpose of continuing health care.

Name: ____________________

Address: ____________________

Phone Number: ____________________ Fax Number: ____________________

Please forward the information indicated below.

- ☐ All Clinical Medical Records
- ☐ All Visual Fields and Related Diagnostics
- ☐ Glasses and Contact Lens Records
- ☐ Other: ____________________

If the information to be disclosed contains any of the types listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed only if I place my initials in the applicable space next to the type of information.

_____ Mental Health Information

_____ Genetic Testing Information

_____ HIV/AIDS Information

_____ Drug/Alcohol Diagnosis/Treatment

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. This consent will expire in 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

____________________ Patient/Representative Signature

____________________ Date

____________________ Relationship to Patient