the eye clinic p.c.

Physicians & Surgeons
Ophthalmology

Diplomates American
Board of Ophthalmology

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

COMPLETE ALL AREAS OF THIS FORM AND MAIL TO YOUR PREVIOUS HEALTHCARE PROVIDER.

Patient: _____

Nickname/Maiden Name/Other: _____

Social Security:_____ Date of Birth: _____

Telephone Number(s): _____

Address: _____

I authorize the healthcare provider/clinic named below to release the following information for the purpose of continuing health care.

Name: _____

Address:_____

Phone Number: _____ Fax Number: _____

Please forward the following information to The Eye Clinic, P.C. at the address indicated on this form.

□ All Clinical Medical Records □ All Visual Fields and Related Diagnostics

□ Glasses and Contact Lens Records □ _____

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