Retina Specialists

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize **Retina Specialists** to release my healthcare information to:

_____

_____

_____

(PH)_____(FX)_____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

_____

☐ All healthcare information

☐ Other: _____

- The purpose for disclosing the information:_____
- I understand that the information used or disclosed may be subject to re-disclosure by the entity or individual receiving the healthcare information from Retina Specialists, and would then no longer be protected by federal privacy regulations.
- I may revoke this authorization by notifying Retina Specialists in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Patient Signature: _____ Date Signed: _____

Patient's Representative: _____ Date Signed: _____
Signature and Description of Authority

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.