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NORTH CAROLINA RETINA ASSOCIATES

RALEIGH-CARY-CLAYTON-DURHAM-WAKE FOREST

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize NC Retina Associates to disclose information to:

Name _____
Address _____
State _____ Zip _____ Phone _____ Fax(required) _____

For the Protected Health Information of:

Patient Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip _____ Phone _____

Information to be Released:

___ All Information ___ Financial Information
___ Medical Information including: history, pictures, and operative reports/procedures
Treatment Dates Requested _____ to _____

Purpose of the use or Disclosure is:

___ Continued Patient Care ___ Social Services Disability ___ Personal Use
___ Insurance ___ Attorney/Legal ___ Other: _____

Rights of the Patient:

I acknowledge that the data released may include material that is protected by law. I understand that I may revoke this authorization at anytime; however, the revocation will not apply to information that has already been released in response to this authorization. I also understand that in order to revoke this authorization, I must do so in writing. The procedure for revoking this authorization is to present my written revocation to NC Retina Associates. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under Federal Privacy Rule. I understand that I may refuse to sign this authorization. NC Retina Associates will not condition the patient's treatment on receiving my signature on this authorization.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition _____.
If I fail to specify an expiration date, event, or condition, this authorization will expire automatically in One year from the date of signature.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

-OR-

Signature of Authorized Representative: _____ Date: _____

Witness: _____ Date: _____