AUTHORIZATION FOR RELEASE OF INFORMATION

Please complete this form in its entirety.

Part A: PATIENT INFORMATION			
First Name:		Middle:	Last Name:
Phone:		Date of Birth:	Email:
Address:	City:	State:	Zip:

The patient listed above authorizes NC Retina Associates to

☐ **OBTAIN** ☐ **RELEASE**

their protected health information to/from the person or company listed below.

Part B: PERSON OR COMPANY TO RECEIVE INFORMATION

☐ Self (same info as above) ☐ Person or Entity:_____

Phone: Fax: Email:

Street Address: City: State: Zip:

Part C: FORMAT AND DELIVERY OF INFORMATION

☐ Print for Pick Up ☐ Fax ☐ Encrypted Email ☐ USPS Mail

Part D: INFORMATION TO BE RELEASED: (check all that apply)

☐ Clinical Notes ☐ Operative/Procedure Notes ☐ Pathology/Laboratory Reports

☐ History and Physical ☐ Billing Records ☐ All Available Medical Records

Treatment/Service dates_____ to _____ ☐ All treatment dates

Part E: PURPOSE OF REQUEST

☐ Personal ☐ Legal ☐ Insurance ☐ Continuation of Care

☐ Disability ☐ 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.

_____ _____

PRINTED NAME OF PATIENT **TODAY'S DATE**

_____

PATIENT SIGNATURE

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