AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name ______________________________ DOB __________________________

Medical Record No. _________________________ SSN __________________________

I, _______________________________ do hereby authorize _________________________________

Name of Patient Name of Provider

to release the specific description of information, including date(s):

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To:

____

Name of Company/Agency/Facility/Person

____

Street Address

____

City, State, Zip Code

____

Expiration

From:

____

Name of Company/Agency/Facility/Person

____

Street Address

____

City, State, Zip Code

____

Expiration

I hereby authorize the use of disclosure of my protected health information as described above. Fees may also apply. I understand that this authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness -for-duty evaluation or a research-related treatment. I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be redisclosed and will no longer be protected. I understand that I have a right to revoke this authorization by sending written notification to the Privacy Officer at Eye Associates of Winchester. Any revocation will not affect disclosures made prior to the Eye Associates of Winchester's receipt or knowledge of the revocation. I understand that I have a right to inspect and receive a copy of the information described on this form.

I certify that I have received a copy of this authorization.

____ ________________________

Signature of Patient or Representative Date

____

Printed Name of Patient or Representative

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Relationship to Patient