CAPE FEAR retina

AUTHORIZATION FOR RELEASE OF INFORMATION

Must be completed for all authorizations.

NAME:_____ Date of Birth: _____
Last First MI

SOCIAL SECURITY NUMBER: _____ HOME PHONE#: _____

SPECIFIC INFORMATION NEEDED:

_____ PHYSICIAN'S NOTES _____ COMPLETE CHART _____ X-RAY REPORTS _____ X-RAY FILMS

_____ LAB REPORTS _____ HISTORY & PHYSICAL _____ DIAGNOSTIC STUDIES _____ PATHOLOGY REPORTS

_____ CONSULTS _____ OTHER: (SPECIFY) _____

PURPOSE: Disclosure of this information is needed for…

_____ CONTINUITY OF MEDICAL CARE _____ INSURANCE PROCESSING _____ LEGAL PROCEEDINGS _____ PERSONAL USE

_____ OTHER: (SPECIFY) _____

AUTHORIZATION: I authorize and request _____ to release medical information to

_____ concerning my treatment for the period of _____ to

_____.

Must be completed for all authorizations

I hereby authorize the use or disclosure of my personal health information as described above. I understand that I may refuse to sign this authorization and that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I understand that I may revoke this authorization at any time by notifying the office in writing and that this will automatically expire on _____/_____/_____ (DD/MM/YR) or 180 days from the date signed below, which ever is earlier.

This hereby releases the sender from all legal responsibility or liability of the release of information described above from the records. I also understand that if I revoke my authorization, it will not have any effect on any actions Cape Fear Retinal Associates, P.C. took before it received the revocation.

I understand that medical records, laboratory reports and billing information may be sent electronically or via facsimile to another medical facility or physician office involved in the care of the patient ore responsible for any part of the patient's charges.

PRINT NAME: _____ DATE: _____
(Patient or Authorized Representative)

SIGNATURE_____ WITNESS: _____
(Patient or Authorized Representative)

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