AUTHORIZATION FOR RELEASE OF INFORMATION

Part A: PATIENT INFORMATION

First Name: Middle: Last:

Date of Birth: / / Phone: ( ) - Email:

Street Address: City: State: Zip:

Part B: PERSON OR COMPANY TO RECEIVE INFORMATION

❑ Self (same info as above)

❑ Person or Entity: ______________________________ Phone: ( ) - Fax: ( ) -

Street Address: City: State: Zip:

Part C: FORMAT AND DELIVERY OF INFORMATION

❑ Printed for pick up ❑ Faxed ❑ Encrypted email ❑ USPS Mail

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

❑ Clinic notes ❑ Operative/Procedure notes ❑ Pathology reports ❑ Radiology reports ❑ Laboratory reports ❑ History and Physical

Treatment dates ________________ to ________________ (please be specific) ❑ All treatment dates

❑ Billing records

Date(s) of service ________________ to ________________ (please be specific) ❑ All service dates

Part E: PURPOSE OF REQUEST

❑ Personal ❑ Legal ❑ Insurance ❑ Continuation of Care ❑ Disability ❑ Other:
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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**

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NC RETINA
ASSOCIATES

PATIENT SIGNATURE