AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
Authorization for Release of Protected Health Information pursuant to HIPAA:

I authorize the release of my Protected Health Information to the following person(s) or organization who can call on my behalf. I authorize disclosing of all my medical records received or created by the Practice., all images/photography of my eye(s), and Billing/Account Information to (please complete):

Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
_____.

When your Protected Health Information is released as provided in this Authorization, the recipient may not have a legal obligation to protect its confidentiality and may re-disclose it.

Expiration of this Authorization:

This Authorization will automatically expire if I send in a written request. And I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.

Your rights with respect to this Authorization:

It is completely your decision whether or not to sign this Authorization. We cannot refuse to treat you if you choose not to sign this Authorization.

If you sign this Authorization, you can revoke it prior to the expiration date above by sending a note in writing to Orlando Eye Institute, to our physical address or email address. The revocation will not have any effect, however, on actions taken in reliance on the Authorization prior to your revocation.

BY MY SIGNATURE, I CERTIFY THAT I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS AUTHORIZATION.

_____ _____
Patient Signature Date