Specialized Pediatric Eye Care & Adult Strabismus

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: __________________________ DOB: ______________ Phone: ______________________________

Home Address: __________________________ City/State/Zip: ____

____I wish to release records of above patient to **Specialized Pediatric Eye Care, Inc. FROM:** **OR** ____I wish to release records of above patient **from Specialized Pediatric Eye Care, Inc. TO:**

Doctor/Clinic/Facility/Other Recipient: ____

Address: ____ City/State/Zip: _________________________________

Phone: (_______) ________________________ Fax: (______) _________________________

Purpose: ____Consult/referral ____Transfer/continuity of care Other (specify): ____________________________

Type(s) of records requested (check all that apply):

____Office Visit Notes ____Visual Fields ____Operative Reports ____Diagnostic imaging ____Lab results

Other: ____

Dates of Service: ____Last Visit Only ____ All visits Other: ___________________________________

This authorization permits Specialized Pediatric Eye Care, Inc. to use and disclose my health information to carry out treatment, payment, or healthcare operations. Additional information regarding the uses and disclosures of health information is described in our Notice of Privacy Policies, which is available to review prior to signing this authorization. A patient has the right to request restrictions on the use and disclosure of health information, but Specialized Pediatric Eye Care, Inc. is not required to agree to such a request for restriction. Unless restricted above, this is an authorization for full release, including information regarding behavioral/mental health, substance abuse treatment, genetic information, HIV/AIDS status, sexually transmitted and other communicable diseases.

I may revoke this authorization in writing at any time, except to the extent that action has already been taken. I understand that upon release of my information, the recipient might not be bound by federal and state privacy regulations. I hereby legally release and hold harmless Specialized Pediatric Eye Care, Inc., its employees, its staff, and its agents in connection with this authorization.

____ __________________________

Signature of Patient/Parent/Guardian/Authorized Representative Date

____

Print Name + Relationship to Patient (if applicable)