The Independent Practices of
RALEIGH
OPHTHALMOLOGY

Authorization for Release of Information

Patient Information:
Name of Patient _____ Date of Birth _____
Address_____
City, State, Zip _____

Raleigh Ophthalmology is authorized to release protected health information pertaining to the above named patient to the entities below.

I have received a copy of the Notice of Privacy Practices for the above named practice.

_____

Signature **Date**

Entity to Receive Information. (Initial each that is subject to this authorization)

_____Leave information voice mail/answering machine. _____Give information to spouse/parents.
_____Leave information with the following persons _____Give information to patient.

_____Name _____Relationship
_____Name _____Relationship
_____Name _____Relationship
_____Name _____Relationship

Description of information to be released (Initial each that is appropriate)
_____ All information
_____ Financial information on billing
_____ Medical information, including results from any tests or x-rays.
_____ Other information as described: _____
_____

Rights of the Patient
I understand that I have the right to revoke this authorization at any time by sending a written notification. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document. I can do this by written notification to:
I understand that my treatment will not be conditioned on signing this authorization.
I understand that I have the right to refuse to sign this authorization.

_____Date _____
Signature of Patient or Personal Representative

_____
Print or Type Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority (attach necessary documentation)

Reason for Non Signature on back