ASSOCIATED OPHTHALMOLOGISTS, PC

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RELEASE OF INFORMATION

NAME: _____ DATE OF BIRTH: _____ SSN#_____

Maiden name/previous name: _____ PARENT(S) NAME, if minor: _____

I HEREBY AUTHORIZE:

PHYSICIAN/CLINIC NAME: _____

ADDRESS: _____

_____

TO RELEASE INFORMATION TO THE FOLLOWING PHYSICIAN/FACILITY:

PHYSICIAN/CLINIC NAME: _____

ADDRESS: _____

_____

PHONE NUMBER: _____ FAX NUMBER: _____

This information can be released as instructed, including medical documentation, opinion or assistance about reports, records, x-rays, labs or any other information or documents you may have in your custody or in your control, with reference to me.

I specifically authorize the following to be released. This confidential information is protected by Federal and/or State law. Please indicate YES or NO in the following blanks:

_____Mental Illness Information

_____AIDS/HIV-related information

_____Drug/Alcohol abuse information

Provide ANY special instructions if limiting to specific dates or information, etc. _____

THE PURPOSE OF THIS DISCLOSURE IS:

_____ Medical Care

_____ Insurance Purposes

_____ Other: _____

PATIENT SIGNATURE: _____ **DATE:** _____

PARENT/LEGAL REPRESENTATIVE SIGNATURE, IF APPROPRIATE: _____

This waiver expires **one (1) year** after the date hereof. I understand that I may revoke this authorization at any time by giving written notice.

*Redisclosure of this information without further written consent is prohibited. The receiver may NOT further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

*A photocopy or facsimile of this authorization, as duly executed, shall have the same force and effect as this original.