AUTHORIZATION TO RELEASE OF INFORMATION

PATIENT INFORMATION:

Name _____ Date of Birth _____

Address _____ Apt# _____

City, State, Zip _____

Cary Eye Center, PLLC. is authorized to release protected health information pertaining to the above named patient to the person(s) or company listed below.

Description of information to be released (please initial each item that you are authorizing to be released)

_____All information

_____Financial/Billing information

_____Medical information including results from any diagnostic tests

_____Other information as described_____

_____

Person(s) or Company to Receive Information

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Patients Rights

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 re-disclosure by the recipient and my 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. 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.

_____

Signature of Patient or Personal Representative Relationship Date

FOR OFFICE USE ONLY

We were unable to obtain the acknowledgment for the following reasons:

_____An emergency existed and signature not possible

_____Unable to communicate with patient

_____Patient refused to sign

_____ Other _____