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Board Certified Ophthalmologist
Vitreoretinal Surgery & Diseases

Retina of Austin, PA

(512) 975-2020 Office
(512) 975-EYES (3937) Fax

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize Retina of Austin, PA to disclose information to:

Name____
Address____

State______________ Zip______________ Phone____________________ Fax(required)__________________________

For the Protected Health Information of:

Patient Name____ Date of Birth ______________________
Address____
City_____________________________ State_______ Zip_____________ Phone_______________________________

Information to be Released:

____ All Information _____ Financial Information
____ Medical Information including: history, pictures, and operative reports/procedures
Treatment Dates Requested ______________________ to ______________________

Purpose of the use or Disclosure is:

____Continued Patient Care ____Social Services Disability ____Personal Use
____ Insurance ____Attorney/Legal ____Other:______________________________

Rights of the Patient:

I acknowledge that the data released may include material that is protected by law. I understand that I may revoke this authorization at anytime; however, the revocation will not apply to information that has already been released in response to this authorization. I also understand that in order to revoke this authorization, I must do so in writing. The procedure for revoking this authorization is to present my written revocation to Retina of Austin, PA. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under Federal Privacy Rule. I understand that I may refuse to sign this authorization. Retina of Austin, PA will not condition the patient's treatment on receiving my signature on this authorization.
Unless otherwise revoked, this authorization will expire on the following date, event, or condition__________________.
If I fail to specify an expiration date, event, or condition, this authorization will expire automatically in One year from the date of signature.

Patient Signature:____Date:___________________________

Witness:_ ____Date:___________________________

-OR-

Signature of Authorized Representative:_________________________________Date:___________________________

Witness:____Date:___________________________