



Enrique Calderon, M.D.  
 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:**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax(required) \_\_\_\_\_

**To Release to Retina of Austin, PA 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: \_\_\_\_\_