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

Patient Information

Name _____ **DOB** _____

Address _____ **City, State & Zip** _____

By agreeing to the following conditions, the patient authorizes Retina of Austin, PA to release protected health information regarding the above patient, including appointment details, financial/billing information, and medical information/diagnostic test results, in the following ways:

Please **INITIAL** the sources to which Retina of Austin, PA may release the above information:

Voice Mail/Answering Machine _____ **Spouse** _____ **Other** _____

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 may no longer be protected by state or federal law. I understand I have the right to inspect or copy the protected health information to be used or disclosed as described in this document, and that I may do this by written notification. I understand my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

Acknowledgment of Receipt – Notice of Privacy Practices

A copy of the Notice of Privacy Practices from Retina of Austin, PA has been made available for me to view.

Patient (please print) _____
Patient Signature _____**Date**_____

If applicable, please complete the section below Personal Representative (please print)

_____

Personal Representative Signature _____**Date**_____

Relationship to patient _____

Authorization for Treatment / Financial Responsibility

I hereby authorize the physicians and staff of Retina of Austin, PA to perform procedures necessary to assess and diagnose my condition properly and such treatments as may be prescribed by my attending physician during any and all visits to Retina of Austin, PA. I understand that I am financially responsible for all charges for services rendered to me by Retina of Austin, PA.

Signature X _____ **Date** _____

For Office Use Only

We were unable to obtain the acknowledgement for the following reason –

- □ **An emergency existed and a signature was not possible.**
- □ **Patient refused to sign.**
- □ **Unable to communicate with patient**
- □ **Other** _____

Prepared by _____ **(please initial)** **Updated Form 2/23/2018**