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Retinal Consultants of San Antonio

Expert Care of the Retina, Macula and Vitreous

AUTHORIZATION TO RECEIVE / RELEASE HEALTH RECORDS

Name: _____ **Date of Birth:** _____/_____/_____
Home Phone: _____ **Cell Phone:** _____

I Hereby Authorize the Disclosure of my Health Information From:
Name of Person/Organization Releasing Information: _____
Address _____
City_____ State_____ Zip Code _____
Office Phone_____ Office Fax _____

To Release my Information To:
Name of Person/Organization Releasing Information: _____
Address _____
City_____ State_____ Zip Code _____
Office Phone_____ Office Fax _____

INFORMATION TO BE RELEASED:
_____Complete Medical Record _____Other: _____
_____Medical Records for Specific Dates of Service from _____ to _____

This authorization remains in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:
I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* 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 by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X_____ _____
Signature of Patient or Legal Representative **Date**

X_____ **X**_____
If Signed by Legal Representative, relationship to Patient **Signature of Witness**
(Attach necessary documents if power of attorney)

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Office Use Only: Date Sent: _____ By: _____ Via: _____