AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Patient Address: _____

Medical Record #: _____ **Date of Birth:** _____

Other Identifier (Social Security #: _____

"I hereby authorize Pasco Eye Institute to make use and disclose my protected health information (information about me in my medical records and/or financial records) as indicated below."

This information is to be disclosed to:

Name of Enity/Family/Friend: _____

Street Address: _____

Phone# _____ Relationship: _____

TO BE READ AND SIGNED BY PATIENT:

I understand the following:

a. I may revoke this authorization at any time by providing written notice to the practice.
b. I may not be able to revoke this authorization if the practice has already taken action if this authorization or if th authorization was obtained as a condition of obtaining insurance coverage.
c. No one has pressured me to sign this authorization.
d. I acknowledge that I have had an opportunity to review this authorization and understand the intect and the use.
e. I have received a copy of this authorization.

Patient Signature: _____ Date: _____

Signature of patients Representative: _____ Relationship: _____ Date: _____

Even or Date upon which authorization will expire: _____