Authorization for Release of Information

Patient Information:

Name ____ Date of Birth ______________

Address ____ Apt# ______________

City, State, Zip ____

Wake Ophthalmology Assoc., PA is authorized to release protected health information pertaining to the above named patient to the entities listed below. *I have been given a copy of the Notice of Privacy Practices for the above named practice.*

Description of information to be released (please **initial** each item that you are authorizing to be released)

_______All information

_______ Financial/Billing information

_______Medical information including results from any diagnostic tests

_______Other information as described:____

____

Entity to Receive Information

Name________________________________ Relationship____________________

Name________________________________ Relationship____________________

Name________________________________ Relationship____________________

Name________________________________ Relationship____________________

Patient Rights

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 federal or state law. 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. I can do this by written notification. I understand that my treatment will not be conditioned on signing this authorization. I understand that I have the right to refuse to sign this authorization.

____

Signature of Patient or Personal Representative Date

____

Print or Type Name of Patient or Personal Representative

____

Description of Personal Representative's Authority (please attach legal documentation)

For Office Use Only:

We were unable to obtain the acknowledgment for the following reason:

_____ An emergency existed and signature not possible _____ Patient refused to sign _____Unable to communicate with patient

_____Other____ Prepared by ____________