105 S.W. Cary Parkway, Suite 200
WAKE OPHTHALMOLOGY ASSOCIATES, P.A. Cary, NC 27511

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Authorization to Release Information to a Health Care Provider

_____

Patient's name (print) Date of Birth

_____

Street Address City, State, Zip

I authorize the use and disclosure of the Protected Health Information for the above named patient as described:

Information Requested:

_____ Records relating to treatment dates from _____ to _____

_____ Records for all care at the facility or by this doctor

_____ Other (Please Specify) _____

Rights of the Patient:

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 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. 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 document. I understand that I have the right to refuse to sign this authorization.

Information to be released ( ) from ( ) to Wake Opthalmology
105 S.W. Cary Parkway, Suite 200
Cary, NC 27511
Phone 919-467-4500
Fax 919-460-9339

( ) from ( ) to _____

_____

_____

Signature of Patient or Personal Representative Date

_____

Personal Representative's name printed (if applicable)

_____

Description of Personal Representative's Authority (attaché necessary documentation)