AUTHORIZATION TO RELEASE HEALTH INFORMATION

PATIENT NAME _____ **DATE OF BIRTH**_____
(FIRST) (MIDDLE INITIAL) (LAST)

The purpose of this release form is to authorize Retina-Vitreous Surgeons of Central NY, PC to make disclosures of Protected Health Information (PHI) to specific individuals who are involved in your care. Such information includes, but is not limited, to diagnosis, procedures, treatment plans, test results, appointments, and billing information including account balances, payments and payment arrangements, and insurance claims status.

Note: If you do not wish to release any health information, please check here and sign at the bottom:

- ❑ I do not authorize the release of health information.

I authorize Retina-Vitreous Surgeons of Central NY, PC to release any personal information relating to my care to:

NAME _____

RELATIONSHIP _____ PHONE _____

NAME _____

RELATIONSHIP _____ PHONE _____

I understand that I have the right to restrict information that may be released and that this restriction must be in writing.

- ❑ No restrictions.
- ❑ With the following restrictions: _____

I understand that it is possible that information used or disclosed with my permission could be disclosed by the recipient and thus would no longer be protected by the federal HIPPA Privacy Rule.

I understand that this authorization remains in effect unless it is revoked. I understand that I have the right to revoke this authorization at any time, except where uses or disclosures have already been made based upon my original permission. To revoke this authorization, I must do so in writing. My written revocation must be submitted to the Privacy Officer for the Retina-Vitreous Surgeons of Central NY, PC.

I understand that this disclosure is voluntary. I do not need to sign this authorization form in order to receive treatment.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____
(PRINTED NAME IF LEGAL GUARDIAN) (RELATIONSHIP TO PATIENT)