



Authorization to Receive / Release Health Information

Patient Information

Patient Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____

Name and Address of Covered Entity to Receive Information

Name and Address of Covered Entity to Release Information

The Information Below Will Be Used for Patient Care

_____ Ophthalmology Records
_____ All Ocular tests—Visual Field, OCT, photos
_____ Medical Records for Specific Dates of Service (please list) from _____ to _____

This authorization shall be 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.

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 to the address below.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. Forward requests to:

Carolina Ophthalmology Associates, P.A.
55 Vilcom Center Drive, Suite 140
Chapel Hill, NC 27514

Printed Name of Patient or Personal Representative

Date

Signature of Patient or Personal Representative

Relationship (if not patient)