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CONSENT TO RELEASE OF INFORMATION

Please PRINT (except signatures) and provide complete answers (and addresses) in each section.

Patient Full Name: _____

Date of Birth: ____/____/____ Social Security Number: _____

Physician: ____ Lyse S. Strnad, M.D. ____ John F. Stamler, M.D., PhD. ____ Stacy L. Thompson, M.D.

I, the undersigned, hereby authorize Eye Physicians and Surgeons, LLP to **RELEASE / OBTAIN** medical information concerning the above named patient to:

Name of Person, Doctor, or Institution Phone FAX

Complete Mailing Address City State Zip

This medical information will contain general medical information, and clinical notes, pertaining to the patients' evaluation and treatment. If specific additional information is necessary, please specify.

(OPTIONAL) Please specify reason for release of information, i.e. continuing medical care, second opinion, moving out of area, etc.

This authorization will automatically expire one year from the date of signature, except as specified _____
Specify # of days or months

- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by recipient and no longer be protected by HIPAA.
- I understand that I may revoke this consent at any time by sending a written notice to: "Medical Records" at Eye Physicians and Surgeons, LLP.
- I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breach of my rights to confidentiality.
- I understand that I may review the disclosed information by contacting: "Medical Records" at Eye Physicians and Surgeons, LLP

* _____
SIGNATURE of Patient OR Legal Guardian DATE

Address City State Zip

Relationship, if Not the Patient Witness

SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE OF FEDERAL LAW

I specifically authorize the release of data and information relating to: (check appropriate box)

☐ 1. Substance Abuse (alcohol/drug abuse) ☐ 2. Mental Health (includes psychological testing) ☐ 3. HIV-Related Information (AIDS related testing)

* _____
Signature of Patient or Legal Guardian Date

* In order for this information to be released, you must sign here AND above, and check the appropriate box(es).

Records Prepared by: _____ Date: ____/____/____ Records Delivered by: ____Mail ____ Fax ____ In person ____ Other