The Independent Practices of
RALEIGH
OPHTHALMOLOGY

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OTHER THAN FOR PAYMENT, TREATMENT, AND HEALTH CARE OPERATIONS

_____ _____
Patient's Name (Print) Guardian or Authorized Party's Name (if Applicable)

_____ _____
Patient's Date of Birth Phone Number for Authorizing Party

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) _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back. To revoke this authorization, I must do so in writing and without my express revocation, this consent will automatically expire 90 days from today's date. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.

Information to be released: [ ] from [ ] to _____
_____
_____

☐ from ☐ to Raleigh Ophthalmology
2709 Blue Ridge Rd., Ste. 100
Raleigh, NC 27607
Phone (919)782-5400
Fax # (919) 782-1680

☐ from ☐ to Raleigh Ophthalmology
10880 Durant Road, Suite 112
Raleigh, NC 27614
Phone (919)870-9100
Fax (919) 532-0331

_____ (Initials of patient or legal guardian) I understand that Raleigh Ophthalmology may not condition treatment on my signing this authorization and that I have a right to refuse to sign this authorization. A fax copy or photocopy of this consent shall be as valid as the original.

_____ _____
Signature of Patient or Legal Guardian Date (Authorization expires in 90 days)

If my medical records include information regarding drug abuse, alcoholism or alcohol abuse, I _____DO _____DO NOT authorize the release of this information.

**If this authorization is signed by an individual's personal representative, the representative's authority is based on (e.g., state law, court order, etc.):_____.

_____
For office use only:

Manager's Authorization _____ Date sent:_____ By:_____