MACULA VITREOUS RETINA
PHYSICIANS & SURGEONS

Authorization For Medical Record Release To Macula Vitreous Retina Physicians & Surgeons

Patient Name:_____ **Date of Birth:** MM/DD/YYYY

Telephone: *Home:* _____ *Work:* _____ *Cell:* _____

Address: _____ **City/State/Zip:** _____

The above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address: _____ **Facility Fax:** _____

City, ST, Zip: _____

Dates of information to disclose:

▢ All dates

▢ Last 2 years

▢ Other: _____

Type of Information to Disclose:

▢ All Medical Records

▢ Ophthalmological/Eye examinations

▢ Other: _____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following organization:

Release to: **Macula Vitreous Retina Physicians & Surgeons, PA, 6655 Travis St, Ste 560, Houston, TX 77030**

Please fax to (832) 547-2221

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.** Further, I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status)

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient