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Administrator

Authorization for Release of Information from Alabama Ophthalmology Associates, P.C.

Patient's Name: _____

Date of Birth: _____

I authorize **Alabama Ophthalmology Associates, P.C.** to disclose the following protected health information (please describe what information you would like to be released; i.e. last chart note or all health information):

_____

_____

Please send the above information to (please include complete address):

_____

_____

This authorization shall be in effect until _____ (please specify date or event) at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

_____
Signature of Patient or Personal Representative (Parent or Guardian)

_____
Date

_____
Name of Patient or Personal Representative **and** Relationship to Patient