ALABAMA
OPHTHALMOLOGY
ASSOCIATES

Ophthalmic Plastic and Reconstructive Surgery

John A. Long
MD, FACS

Matthew G. Vicinanzo
MD, FACS

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MD (Fellow)

Cornea, External Disease and Anterior Segment

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Pediatric Ophthalmology and Strabismus

Jennifer D. Davidson
MD

Allison C. McKelvey
OD

Administrator

Brooke E. Dover
CPA

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

Patient's Name: _____

Date of Birth: _____

I authorize _____

Address: _____

Phone: _____

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) to **Alabama Ophthalmology Associates, PC** (the Company), 1000 19th Street South, Birmingham, AL 35205:

_____

_____

_____

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 by sending such written notification to the Company. I understand that that a revocation is not effective to the extent that the Company has relied on the use or disclosure of the protected health information.

_____

Signature of Patient or Personal Representative (Parent or Guardian)

_____

Date

_____

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