

Associated Ophthalmologists, PC
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RELEASE OF INFORMATION

Patient Name (Print)	Date of Birth	Social Security Number
Maiden Name or Previous Name	Parent(s) Name if Minor	

I HEREBY AUTHORIZE INFORMATION TO BE RELEASED BY:

PHYSICIAN'S NAME AND ADDRESS

PLEASE GIVE/SEND THIS INFORMATION TO:

PHYSICIAN/AGENCY

ADDRESS

This information can be released as instructed, including medical documentation, opinion, or assistance about reports, records, or x-rays, or any other information or documents that you may have in your custody or in your control, with reference to me.

I specifically authorize the following to be released. This confidential information is protected by Federal and/or State Law*. Please indicate YES or NO and please initial for your authorization.

- _____ Mental Illness information
- _____ Aids or HIV-related information
- _____ Drug or Alcohol abuse information

Special instructions (if limiting to specific dates or information, etc.)

The purpose of this disclosure is:

- 1. _____ Medical Care
- 2. _____ Insurance Purposes
- 3. _____ Other _____

PATIENT SIGNATURE

DATE

PARENT/LEGAL REPRESENTATIVE SIGNATURE (IF APPROPRIATE)

This waiver expires one year after the date hereof. I understand that I may revoke this authorization at any time by giving written notice.

***Note:** Redislosure of this information without further written consent is prohibited. The receiver may NOT further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A photocopy or facsimile of this authorization, as duly executed, shall have the same force and effect as this original.