SILVER SPRING EYE
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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

_____

Telephone #:_____

Today's Date: _____

I, or my Legal Representative, authorize:

Name of Healthcare Provider/Practice: _____

Address: _____

Fax # _____

To Disclose to Silver Spring Eye:

- All medical records including patient histories, office note, test results, radiology studies, films, and referrals.

I do not want the following information disclosed: (check all that apply)
HIV Test Results ___ Alcohol/Drug Abuse ___
Mental Health/Developmental Disabilities ___

Dates of Information to be disclosed: *From:* _____ *To:* _____

Reason for Release:

- *Continuing Care*
- *Legal*
- *Other (please specify)* _____

I understand that I have a right to cancel/revoke this authorization at any time by notifying the disclosing medical records department in writing. I am aware that my revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise cancelled/revoked this authorization will expire one year from this date: _____

Printed Name of Patient/Legal Guardian/Representative: _____
Signature of Patient or Legal Guardian/Legal Representative: _____
Date: _____
Relationship to Patient, if signed by Legal Guardian: _____

Effective 7-10-15