BERKELEY OPHTHALMOLOGY MEDICAL GROUP, INC.
Richard L. Litwin, M.D. ● Joshua P. Litwin, M.D.
Susan Su, O.D.
Ophthalmic Surgery
L-5 Rev. 04/17

Privacy Officer: Business Administrator

Telephone #: 510-548-6630

As required by the health information portability and accountability act of 1996 (HIPAA) and California law, this practice may not use or disclose your individually identifiable health information except as provided in our notice of privacy practices without your authorization. Your completion of this form means that you are giving permission for the uses and disclosure described on the on the backside of this form. Please review and complete this form carefully. It may be invalid if not fully completed. You may wish to ask the person or entity you want to receive your information to complete the sections detailing the information to be released and the purposes for disclosure.

I have read and understood the paragraph above.

Initials: _____

Records Release on Back

2999 REGENT STREET, SUITE 425 • BERKELEY, CA 94705-2119
PHONE (510) 548-6630 • FAX (510) 548-9765

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I hereby authorize:

BERKELEY OPHTHALMOLOGY
MEDICAL GROUP, INC.
RICHARD L. LITWIN, M.D.
JOSHUA P. LITWIN, M.D.
SUSAN SU, O.D.
2999 REGENT STREET, SUITE 425
BERKELEY, CA 94705-2119
Phone (510) 548-6630 Fax (510) 548-9765

To disclose to:

_____
Name of Party

_____
Address

_____
City State ZIP Code

_____ _____
Phone Number Fax Number

Patient Health Information Pertaining to:

_____ _____
Name of Patient Date of Birth

_____
Address City State ZIP Code

_____
Telephone Number

Revocation: I understand that I may revoke this authorization at any time notifying this medical practice in writing. My revocation will not affect actions taken by this medical practice prior to its receipt.

Re-disclosure: I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearing house, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

Duration: This authorization is effective now and will remain in effect until one year after the date signed below.

Specify Records:

☐ A copy of my medical eye records only.
☐ A summary of my diagnosis and treatment.
☐ Hospital Admissions (include admission H&P and discharge summary)
☐ Other Health Information: _____

A copy of this Authorization is as valid as the original. Patient has right to a copy of this authorization.

_____ _____ _____
Signature Date (Void after one year) Relationship if signed by other than Patient