Carolina Eye Care, PA
Authorization to Release Health Information

Patient Information:

Name of Patient _____ Date of Birth _____

Address_____

City, State, Zip _____

Release information to:

_____

(Name) (Relationship to Patient)

_____

(Name) (Relationship to Patient)

This information will be released at the patient's request:

___ Financial only ___ Financial & Medical

___ Medical only ___ other

This authorization shall be in effect until the information has been forwarded as requested.

Rights of the Patient

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to _____ _____.

_____Date _____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority (attach necessary documentation)