AUTHORIZATION TO RELEASE/REQUEST PROTECTED HEALTH INFORMATION

(*Check One*)

Release _____ Releasing information from us to you or your provider
Request _____ Requesting information from another provider to us

Date_____
Patient's Name_____ Date of Birth_____
Address_____
Phone Number_____ Social Security Number_____

I authorize the San Antonio Eye Institute, PLLC to **release / request** (*Circle One*) the following:

Clinic Notes	Laser/Surgery Notes	Consultation Notes
Lab Reports	Pathology Reports	Photos/Special Testing

Other (specify)_____

Purpose of Request (*Circle All That Apply*)

Continued Medical Care	Insurance (for payment)	Legal Counsel
Social Security	Worker's Compensation	

Other (specify)_____

Please note if there are specific uses & limitations on use of the information by the recipient:
_____

Duration of Authorization_____
To / From (*Circle One*) Name San Antonio Eye Institute, PLLC_____
Address 12227 Huebner Road, Suite 110, San Antonio, Texas 78230_____
Phone and Fax: Phone: (210) 485-1488/Fax: (210 485-1489_____

- I understand that this authorization shall be valid through _____ (date), but that I may revoke it in writing at any time; any such revocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and copy the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/or may be unable to provide the most appropriate care for me.
- I understand that the release of information may not be re-released to any other person or organization without my written consent.

Signature_____ Date_____