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DIPLOMATE, AMERICAN BOARD OF OPHTHALMOLOGY
DISEASES OF THE RETINA & VITREOUS

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Today's Date: _____

☐ **REQUESTING MEDICAL RECORDS** ☐ **SENDING MEDICAL RECORDS**

Completion of this document authorizes the disclosure and use of health information about you.

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Phone: _____ Patient Email: (Optional) _____

SECTION 1 - Authorization:

I AUTHORIZE *VISIONARY RETINA CENTER* TO: ☐ RELEASE TO OR ☐ OBTAIN FROM

MY HEALTH CARE INFORMATION

Please Note: It can take up to 10 business days for records to be delivered.

Practice/Institution/Physician/Self: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

SECTION 2 – Health Information: This request and authorization applies to:

- Only healthcare information relating to the following treatments and conditions:

  _____

- ALL Healthcare Information and records, including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

- I specifically authorize the release of the following information:
  - Yes ☐ No ☐ Mental health treatment information
  - Yes ☐ No ☐ Communicable diseases including, but not limited to, HIV and AIDS
  - Yes ☐ No ☐ Alcohol/drug treatment information
  - Yes ☐ No ☐ Genetic information

- Other: _____

SECTION 3 - Purpose: Purpose of requested use or disclosure and limitations, if any:

_____

_____

SECTION 4 - Method of Delivery:

☐ Pick-up ☐ Mail ☐ Electronic Copy ☐ Fax to #: _____

SECTION 5 - Types of Records Requested: (Please inquire about any associated fees.)

☐ Exam Notes ☐ Consult Letters ☐ Lab Results ☐ Other:_____

SECTION 6 - Time Period: The medical records in your possession concerning my illness and/or treatment during the period:

_____/_____/_____ to _____/_____/_____

SECTION 7 - Your Rights:

- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to Visionary Retina Center 23622 Calabasas Road, Suite 145, Calabasas, CA 91302. My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving your health information from making further disclosures of it unless another authorization for such disclosure is obtained from you or unless such disclosure is specifically required or permitted by law.

SECTION 8 - Duration: THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED.

SECTION 9 - Signature:

Patient Signature:_____ Date :_____

Print Patient Name:_____

If this form is being completed by a person with legal authority to act an individual's behalf,

such as a parent or legal guardian of a minor or health care agent, please complete the

following information:

- Name of person completing this form: _____
- Signature of person completing this form: _____
- Describe below how this person has the legal authority to sign this form:

  _____

  _____