MID-ATLANTIC EYECARE

An AVP Company

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name _____ DOB _____

Medical Record No. _____ SSN _____

I, _____ do hereby authorize _____

Name of Patient Name of Provider

to release the specific description of information, including date(s):

_____

_____

_____

To:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip Code

_____
Expiration

From:

_____
Name of Company/Agency/Facility/Person

_____
Street Address

_____
City, State, Zip Code

_____
Expiration

I hereby authorize the use of disclosure of my protected health information as described above. Fees may also apply. I understand that this authorization is voluntary. I understand that ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness -for-duty evaluation or a research-related treatment. I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be redisclosed and will no longer be protected. I understand that I have a right to revoke this authorization by sending written notification to the Privacy Officer at Mid-Atlantic Eye Care. Any revocation will not affect disclosures made prior to Mid-Atlantic Eye Care's receipt or knowledge of the revocation. I understand that I have a right to inspect and receive a copy of the information described on this form.

I certify that I have received a copy of this authorization.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name of Patient or Representative

_____
Relationship to Patient