**RETINA CONSULTANTS OF HOUSTON**
6560 Fannin Street, Suite 750 Houston, TX 77030
Phone (713) 524-3434 FAX (713) 524-3220

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Retina Consultants of Houston to disclose my protected health information to the following family and friends:

| NAME | NAME |
|---|---|
| ______________________ | ______________________ |
| ______________________ | ______________________ |

I authorize the disclosure of the protected health information as indicated below:

| Release | Do Not Release | Information | Release | Do Not Release | Information |
|---|---|---|---|---|---|
| ____ | ____ | History/Consult | ____ | ____ | Treatment Plan |
| ____ | ____ | Diagnosis | ____ | ____ | Operative Reports |
| ____ | ____ | Findings on Exam | ____ | ____ | Clinic/Progess Notes |
| ____ | ____ | Diagnostic Studies | ____ | ____ | Laboratory Reports |
| ____ | ____ | Return to Work/ Status/Restrictions | ____ | ____ | Other (specify): |

Purpose of disclosure: ____________ ______ Insurance
______________________

I understand that Retina Consultants of Houston will not place any conditions on my treatment, payment, enrollment in a health plan,or eligibility for benefits based on whether or not I provide authorization or the purpose of disclosure for any of the above information.
I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
This authorization shall be effective until the following date: ______________
(if not indicated otherwise, authorization will be effective for 12 months from the date signed).
I understand that I have the right to revoke this authorization at any time by sending written notification to the attention of:

Name: Retina Consultants of Houston Attn: Chris Hunckler
Address: 6560 Fannin Street, Suite 750 Houston, TX 77030
Phone/Fax (713) 524-3434 / (713) 524-3220

I understand that a revocation does not affect any information released according to the terms of this authorization prior to the receipt of the written notification of revocation. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.
I agree that disclosure of the information indicated may be transmitted by fax Yes / No
I agree that a photocopy of this authorization may be considered valid Yes / No

Patient/ Guardian (Signature)______________________ Date: ______________

Patient Name (Printed) ______________________ DOB: ____________

Witness (Signature) ______________________