

VITREORETINAL CONSULTANTS

6560 FANNIN SUITE 750 HOUSTON, TX 77030

PHONE 713-524-3434 FAX 713-524-3220

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Vitreoretinal Consultatns to disclose my protected health information to the following of my 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/Progress Notes
_____	_____	Diagnostic Studies	_____	_____	Laboratory Reports
_____	_____	Return to Work/ Status/Restrictions	_____	_____	Other (specify):

Purpose of disclosure:

_____ Insurance

I understand that Vitreoretinal Conusltants 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 Vitreoretinal Consultants to the attention of:

Name: Vitreoretinal Consultants Attn: Medical records
Address: 6560 Fannin 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 ma by 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) _____