Authorization to Receive/Release Health Information

ALAMEDA EYE CENTER

Patient Name _____ Date of Birth _____

Address _____ City / State / Zip _____

I Hereby Authorize the Disclosure of my Health Information From:

Alameda Eye Center, PC
Name of Person/Organization Releasing Information

2418 Central Ave Alameda, CA 94501
Address City / State / Zip

(510) 519-8066 // (888) 981-4312
Phone Number // Fax Number

To Release my Information To:

_____
Name of Person/Organization Receiving Information

_____
Address City / State / Zip

_____
Phone Number // Fax Number

INFORMATION TO BE RELEASED:
_____Complete Medical Record
_____Medical Records for Specific Dates of Service (please list) from _____ to _____
_____Other (please list) _____

This authorization remain in effect until the information has been forwarded as requested.

RIGHTS OF THE PATIENT:
I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPPA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

X_____ X_____
Printed Name of Patient or Personal Representative Signature of Patient or Personal Representative

_____ _____
Relationship to Patient (attach necessary documentation) DATE

OFFICE USE ONLY: **Date Sent:** _____ **By:** _____ **Via:** _____