Authorization for Release of Patient Information

for your eyes...don't compromise!

SAN ANTONIO EYE SPECIALISTS

I request and authorize San Antonio Eye Specialists to:

☐ Receive the following information from: ☐ Release the following information to:

Name: _____	San Antonio Eye Specialists
Street Address: _____	2810 N Loop 1604 W, Suite 200
City, State, Zip: _____	San Antonio, Texas 78248
Tel. No.: _____	Fax: (210) 822-9810, Phone: (210) 822-9800

Release is for the Purpose of:

- ☐ Continued Care by other health care provider
- ☐ Insurance
- ☐ Personal Review
- ☐ Other (please specify) _____
- ☐ Disability
- ☐ School
- ☐ Attorney

Information to be disclosed if requested:

- ☐ Last visit
- ☐ One year
- ☐ Two years
- ☐ Complete medical record
- ☐ Other (please specify) _____
- ☐ X-ray results
- ☐ Lab results
- ☐ Billing statement

I understand and agree that the information I am authorizing to be released may include:

(1) AIDS/HIV test results, diagnosis, treatment, and related information;
(2) Drug screen results and information about drug and alcohol use and treatment;
(3) Physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion,
(4) Mental health information; and/ or
(5) Genetics testing.

I further understand that this Authorization is voluntary and I may refuse to sign this Authorization. I further understand that my treatment will not be affected if I do not sign this form. I further understand that I may revoke this Authorization at any time by notifying San Antonio Eye Specialists in writing, except to the extent that action has been taken in reliance on it. Unless earlier revoked, this Authorization expires automatically 90 days from the day signed or 90 days after the last visit or after all insurance or third party claims have been paid or satisfactorily resolved, whichever occurs last.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

I further understand that I may refer to San Antonio Eye SpecialistsôNotice of Privacy Practices.

RELEASE FROM LIABILITY I release and agree to hold harmless San Antonio Eye Specialists and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accord with this Authorization. I understand that San Antonio Eye Specialists cannot be responsible for use or re-disclosure of information to third parties.

TO THE RECEIVING PARTY OF THIS INFORMATION: This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation. If the healthcare services (including examination and drug screening) are being provided at the request of and being paid for by my employer (or prospective employer), I understand and agree that all records and information related to the healthcare services provided to me may be given directly to my employer and if I wish to obtain such information, I should contact my employer/prospective employee.

I consent to have the above information released. I further certify that this form has been fully explained to me, that I have read it or had it read to me, and that I understand its contents.

Patient Signature _____ Print Name _____ Date _____

Rev 6/16