lehigh eye specialists

RELEASE OF INFORMATION

_____ _____ _____
Patient Name (print) Date of Birth Social Security #

_____ _____
Maiden Name or Previous Name Parent(s) Name if Minor

I HEREBY AUTHORIZE LEHIGH EYE SPECIALISTS TO RELEASE MY INFORMATION TO:

_____
Physician Name/ Practice

_____
Address

_____

This information can be released as instructed, including medical documentation, opinion, or assistance about reports, records, or x-rays, or any other information or documents that you may have in your custody or in your control, with reference to me. I understand that electronic medical records will be provided on a USB hard drive. Please note that this USB drive is NOT encrypted. Take care not to lose or misplace it as this contains your personal medical information.

I specifically authorize the following to be released. This confidential information is protected by Federal and/or State Law. *Please indicate YES or NO and please initial for your authorization.

_____ Mental Illness Information
_____ Aids or HIV- related Information
_____ Drug or Alcohol Abuse Information

The purpose of this disclosure is: _____ Medical Care _____ Insurance Purpose_____ Other _____

_____ _____
Patients Signature Date

_____
Patient/Legal Representative Signature (if appropriate)

This waiver expires one year after the date hereof. I understand that I may revoke this authorization at any time by giving written notice.
*Note: Re-disclosure or this information without further written consent is prohibited. The receiver may NOT further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.
A photocopy or facsimile of this authorization, as duly executed, shall have the same force and effect as this original.