Medical Information Release Form (HIPAA)

Name: ___________________________________ **Date of Birth: ____/_____/____**

Release of Information

❑ I authorize Annandale Eye Clinic to discuss ALL ASPECTS of my protected health information including examination(s), test results, diagnoses, billing and claims information, and prescription information rendered to me with the individual(s) listed below:

Name: __________________________ Relationship: ____________________

Name: __________________________ Relationship: ____________________

Name: __________________________ Relationship: ____________________

❑ Information is not to be released to anyone

Messages

If unable to reach me:

❑ You may leave a detailed message

❑ Please leave a message asking me to return your call

Signed: ________________________________ Date: _____/______/_________

This Release of Information will remain in effect until terminated/changed by me in writing.