55 Vilcom Center Dr, Suite 110
Chapel Hill, NC 27514
Phone: 919-929-7990
Fax: 919-929-7991

Medical Records Release and
Authorization for Use or Disclosure of Protected Health Information

Patient name: ____

Date of birth: ______________________ SSN: ______________________________

Phone #____

I authorize my former Eye Doctor's office,

____

(fill in name of former doctor or practice)

To disclose the Protected Health Information requested below to:

☐ Triangle Ophthalmology, PA

Information to be disclosed:

☐ All Information including progress notes, visual fields, photos, &other diagnostic testing

☐ Specific information: _____________________________________

This information will be used for:

☐ At the request of the patient

☐ To transfer medical care

☐ Other:____

This authorization will be in effect until

☐ the following event:__________________or ☐ Date: _____________

☐ until further notice

I may revoke this authorization at any time, in writing, sent to Triangle Ophthalmology, PA at the address provided below. If I do, it will not affect any actions already taken by Triangle Ophthalmology, PA based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

____

Patient or legally authorized individual signature Date Time

Patient is unable to sign because of: ____

Age of minor or reason for patient's inability to sign