Coronado Eye Associates

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: FORMTEXT Date of Birth: FORMTEXT
Previous Name: FORMTEXT Social Security #: FORMTEXT
I request and authorize FORMTEXT to release healthcare information of the patient named above to:

Name: FORMTEXT
Address: FORMTEXT
City: FORMTEXT State: FORMTEXT Zip Code: FORMTEXT

This request and authorization applies to:

FORMCHECKBOX Healthcare information relating to the following treatment, condition, or dates: FORMTEXT

FORMCHECKBOX All healthcare information

FORMCHECKBOX Other: FORMTEXT

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to our practice. You should contact our privacy officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. It may not be possible to ensure your right to the protection of the privacy of this information once our practice discloses it to another party.

Rights of the Individual
You may inspect or copy information used or disclosed under this authorization
You may refuse to sign this authorization

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED