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

Patient name: _____

Date of birth: _____ SSN: _____

I authorize my former Eye Doctor's office,

_____

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