AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name (Print): _____

Address: _____

Date of Birth:_____

Date Records Requested:_____

I, patient undersigned below, authorize your doctor's office information below:

- Your eye doctor's name:_____
- Your eye doctor's address:_____
- Your eye doctor's phone:_____

to release or obtain my medical information, receipts of payment or balance due, and/or other information considered under the HIPAA privacy law to be part of the Designated Record Set to the following contact or entity:

Name of Agency:
The Alabama Cornea Care Center, LLC
Attn: Patient Care Coordinator
700 Boulevard South, SW, STE 104, Huntsville AL 35802
Telephone: 256.9371213
Email: EyeExams@AlabamaCorneaCare.com
Fax # (if applicable) __Call main line to set up fax_____

Your office and the recipient designated above are released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient Signature_____ Date _____

Notice to Person or Agency receiving this information: This information has been disclosed to you from records whose confidentiality is protected. Statutes and regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.