Sakowitz Eye Center
2850 Wellness Ave Orange City, FL 32763
Phone (386) 574-0700 Fax (386) 574-1139

Records Release - HIPAA Compliant

Patient Name: _____

Date of Birth: _____ Social Security # _____

I authorize and request the disclosure of all protected information of the above named individual's health information. I expressly request that the designated record custodian of all covered entities are under HIPAA identified above disclose full and complete protected medical information. I hereby authorize you to release any information including the diagnosis and records of any treatment or examination rendered to me during my treatment period, including visual fields, photos and operative reports.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

This protected health information is disclosed for the purpose of continued ocular medical care:

I understand the following:

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization
- The information released in repsonse to this authorization may be re-disclosed to other parties.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.
- I understand that once the information listed above has been disclosed, it may be re-disclosed by the recipient and federal privacy laws or regulations may not protect the information.

Any facsimile, copy or photography of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from the date of execution at which time this authorization expires.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Name and Relationship of Legally Authorized Representative to Patient

_____ _____
Witness Signature Date