

Dr. _____ Address: _____
Please release my clinical records to Kenneth Gatson O.D./Kristine Verkaik, O.D./Robyn Glass,O.D./
Lori Mills Helman, O.D.
Central Florida Eye Center, 2303 S. Bay St. Eustis, FL 32726 Ph:352-357-1027 Fax: 352-357-1029

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____ DOB _____

Patient address _____

Patient phone number _____

I authorize the professional office named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: All clinical notes.
2. To whom may the information be released: Kenneth Gatson,O.D./Kristine Verkaik,O.D./Robyn Glass, O.D./Lori Mills Helman, O.D.
3. The purpose for the release: At the request of the individual. _____
(Please Initial)
4. Expiration date relating to the individual or purpose for the release: No expiration date.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to an office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____
Source of Authority _____