AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____
First MI Last MM/DD/YYYY

I hereby authorize: _____

_____

_____

to disclose the above named individual's protected health information as described below:

Dates of Service (If known) or ☐ **ALL**: _____

Provider (if known) or ☐ **ALL**: _____

Description of Information to be released: (check all that apply) ☐ **ENTIRE MEDICAL RECORD**

☐ Immunization Record	☐ Diagnostic Imaging Reports	☐ Consultation Reports
☐ Progress Notes	☐ Diagnostic Imaging Films	☐ Operative Reports
☐ History & Physical	☐ Laboratory Reports	☐ Other:_____

This information may be disclosed to and used by the following individual(s) and/or organization(s):

Retina Associates
3525 Prytania Street, Suite 320
New Orleans, LA 70115
Tel: 504-895-3961
Fax: 504-895-6716

Gerald Cohen, M.D.
Gwen M. Cousins, M.D.
Ronald L. Willson, M.D.
Stanislav A. Zhuk, M.D.
The Foundation for Retinal Research

Description of the purpose of the use and/disclosure:

☐ **Continuity of Care, Provider to Provider** ☐ **Other: _____**

I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my health care and the payment of my health care with not be affected if I do not sign this form. I understand I may inspect or copy the information to be used or disclosed. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state privacy regulations. I understand the holder of information may charge a processing fee for this service. I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. This authorization will be in effect until _____ (date or event).

I understand I may revoke this authorization at any time by notifying the Practice Administrator at Retina Associates. I understand that if I revoke this authorization, I must do so in writing and the written revocation must be signed and dated with a date later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____
Signature of Patient or Patient's Representative Date (MM/DD/YYYY)

_____
Printed Name of Patient or Patient's Representative

_____ _____
Relationship to Patient Legal Authority (attach supporting documentation)