Stokes Regional Eye Centers

Patient Authorization to Disclose Protected Health Information

Patient Name_____**Chart #**_____

Birthdate_____**Social Security#**_____

I hereby authorize the use and disclosure of my protected health information as described below:

Individual or entity authorized to disclose information:	**Individual or entity authorized to receive information:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Specific dates of service to be released:_____

Purpose of disclosure: **( ) continue medical care**
( ) second opinion
( ) personal use of patient

I understand that the first copy of my records will be provided at no charge and that there will be a fee for reproduction of photos. I understand that additional copies of my office notes will be provided with a prepayment of $15.00. I understand that I may revoke in writing this authorization at any time. However, I understand that my revocation will not affect any actions taken before receiving my revocation. This authorization shall expire one year from date of signature.

_____ _____
Signature of patient or legal guardian (if minor) **Date**

_____
Address

_____ _____
Witness of signature **Relationship (if not patient)**

For office use only

Description of information sent_____
Date sent_____
Sent by ( ) mail ( ) fax#_____
SREC office personnel that processed request_____