Edward R. Rashid, M.D., F.A.C.S.
William J. Flynn, M.D., O.D.
Charles D. Reilly, M.D
Gregory M. Brunin, M.D.

Anhtuan H. Nguyen, M.D
Melanie Gonzalez-Oliva, O.D.
Mark G. Carolan, O.D.
George Nicolas, Jr., O.D.

RASHID, RICE, FLYNN & REILLY
Eye Associates

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of health information from the medical record of:

Patient Name: _____ Date of Birth: _____

Patient Address: _____City / State / Zip _____

THIS IS TO AUTHORIZE: ☐ Rashid & Rice Eye Associates, PLLC ☐ _____

_____

TO DISCLOSE INFORMATION TO: _____

_____

FOR THE PURPOSE OF: Medical Care:____ Work: ____School: ____ Insurance:____ Other: _____

PLEASE RELEASE THE FOLLOWING: Complete Record _____ ; Records of Care from _____ to _____;

RIGHTS OF THE PATIENT:

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address below. Unless revoked, this authorization will expire in 180 days. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that the information released may include sensitive information to include information relating to HIV/AIDS information, alcohol and/or drug abuse, and other health information. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. *Any information received by this office for our own use will continue to be protected by the Federal Privacy Rule (HIPAA).* I understand that I have the right to inspect or copy the protected health information to be used or disclosed as described in this document by written notification. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. If I have questions about disclosure of my health information, I can contact the Medical Records Custodian, Rashid, Rice, Flynn, and Reilly Eye Associates, PLLC.

I understand that you may charge a fee (to be paid in advance) for preparing and furnishing this information. A fee schedule is available upon request.

_____ _____

Signature of Patient or Legally Authorized Representative Date

_____ _____

Relationship to Patient (If Legal Representative) Witness

Mailed: _____ FAXed: _____ Delivered/Handed Over: _____ By: _____

San Antonio (Main Office)
5430 Fredericksburg Road
Suite 100
San Antonio, TX 78229
(210) 340-1212
FAX (210) 340-1505

Boerne
113 Falls Court
Suite 100
Boerne, TX 78006
(830) 248-1222
FAX (830) 248-1333

Alamo Ranch
11345 Alamo Ranch Parkway
Suite 201
San Antonio, TX 78253
(210) 617-7396
FAX (210) 617-7383

Kerrville
1446 Sidney Baker
Kerrville, TX 78028
(830) 792-4466
FAX (830) 792-4640