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Charles D. Reilly, M.D.
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Melanie P. Gonzalez-Oliva, O.D.

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO EYE ASSOCIATES

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 (name of doctor): _____ Phone: _____

Address: _____ FAX: _____

TO DISCLOSE INFORMATION TO: Rashid, Rice, Flynn, & Reilly Eye Associates, PLLC Doctor: _____
FAX #: 210-525-9617

FOR THE PURPOSE OF: Medical Care: ___ Work: ___ School: ___ Insurance: ___ Other: _____

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

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 Legal Representative

Date

Relationship to Patient (If Legal Representative)

Witness

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

San Antonio (Main Office)	Alamo Ranch	Boerne	Kerrville
5430 Fredericksburg Road, Suite 100 San Antonio, TX 78229 (210) 340-1212 · FAX (210) 340-1505 Billing Office FAX (210) 525-9617	11345 Alamo Ranch Pkwy Suite 201 San Antonio, TX 78253 (210) 617-7396	113 Falls Court, Suite 100 Boerne, TX 78006 (830) 248-1222 FAX (830) 248-1333	1446 Sidney Baker Kerrville, TX 78028 (830) 792-4466 FAX (830) 792-4640