William J. Flynn, M.D., O.D.
Gregory M. Brunin, M.D.
Anhtuan Nguyen, M.D.
Matthew C. Caldwell, M.D.

Eye Associates

Michael E. Offutt, M.D.
Mark G. Carolan, O.D.
Melanie Gonzalez-Oliva, O.D.
Teresa H. Chui, 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: _____ DOB: _____

Patient Address: _____ City / State / Zip _____

THIS IS TO AUTHORIZE (name of doctor): _____ Phone: _____

Address: _____ FAX: _____

TO DISCLOSE INFORMATION TO: **Rashid and Rice 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: _____ By: _____