

Riverside Eye Center
Dr. Martin Whitaker
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION

I hereby authorize _____ to use or disclose the following protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient name _____ Date of Birth _____

Address _____

Information to be disclosed to: _____

Disclose the following information

Complete records Consult Pathology, Lab or X-Ray HIV, Substance Abuse,
Mental Health

Emergency Reports Surgery Reports Other Specified

The above information is disclosed for the following purposes:

Medical Care Legal Insurance Personal Other _____

I understand I may revoke this authorization at any time by requesting such of the above referenced hospital/physician practice in writing, unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

This authorization expires on _____

Signature of patient or legal representative _____

Printed name of patient or patients representative _____

Date _____ Relationship to patient _____

