Meadows Eye
Physicians & Surgeons

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

REQUEST TO SEND RECORDS

I date of birth

hereby authorize Meadows Eye to release all records to:

Name

Address

City, State , Zip

Phone/Fax

I authorize the use or disclosure of my individually identifiable health information as described above for the purpose listed. I have the right to withdraw permission for the release of my information. I can revoke that authorization at any time athought this revocation must be made in writing and will not affect information that has already been used or disclosed. I have the right to receive a copy of this authorization. I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization. I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE AUTHORIZATION

SIGNATURE: DATE

PRINTED NAME: TIME