HERTZOG FAMILY

EYE CARE

1004 S. Pine St Suite F
Cabot, AR 72023
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info@hertzogfamilyeyecare.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: ______________________________ Date of Birth: ______________

I authorize the use and/or disclosure of my protected health information (medical records) as described below.

I authorize **Hertzog Family Eye Care:** ☐ **to release information to**

☐ **to obtain information from** (Check either or both boxes as needed)

Name of facility/provider: ______________________________

Address: ______________________________

City, State, Zip: ______________________________

Phone: ____________________ Fax: ____________________

The purpose of the release is:

☐ At the request of individual ☐ Diagnostic Evaluation ☐ Coordination of Care ☐ Change of Physician

☐ Other: ______________________________

The following information may be released:

☐ **Eye/vision exam records** ☐ Special testing reports ☐ Physician letters ☐ Medication list

☐ Other: ______________________________

You have the right to revoke this Authorization at any time, provided you do so in writing. If you revoke your Authorization we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any disclosures already made with your permission. To evoke your records release with this authorization, please send a written statement to our clinic at the address listed above.

I have reviewed and I understand this authorization. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

______________________________ ______________________________

Signature of patient or representative Print Name

______________________________ ______________________________

Relationship (if signed by representative) Date