



Authorization to Release Protected Health Information

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

The patient listed above authorizes Retina of Coastal Carolina to
[ ] obtain - or - [ ] release
their protected health information to / from the company / person listed below:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Information to Release:

[ ] Medical Records [ ] Billing Records [ ] All Available Records

Service Dates: \_\_\_\_\_ to \_\_\_\_\_ [ ] All Dates

Format of Delivery:

[ ] Print for Pick Up [ ] Fax [ ] USPS Mail [ ] Encrypted E-Mail

Patient's Rights:

- I have the right to revoke this authorization at any time in person or in writing.
I may inspect or copy the protected health information to be disclosed as described in this document.
Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
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.
I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: \_\_\_\_\_ Date: \_\_\_\_\_