SAN ANTONIO EYE & FACE INSTITUTE

AUTHORIZATION TO RELEASE/REQUEST PROTECTED HEALTH INFORMATION

(CHECK ONE)
Release ____ Releasing information from us to you or your provider
Request____ Requesting information from another provider to us

Date: _____
Patient's Name:_____ DOB:_____
Address:_____
Phone Number:_____ Last 4 of SSN:_____

I authorize the San Antonio Eye & Face Institute to **release / request** (check all that apply) of the following:
_ Clinic Notes _ Laser/Surgery Notes _ HVF's
_ Lab Reports _ Pathology Reports _ NFL Analyses (in color)
Other:_____

Purpose for request (Check all that apply)
_ Continued Medical Care _ Insurance (for payment) _ Legal Counsel
_ Social Security _ Worker's Compensation
Other (specify)_____

Please note if there are specific uses & limitations on use of the information by the recipient:_____

Duration of Authorization: 1 Year from date signed.
To/From: San Antonio Eye & Face Institute
Address: 4456 Lockhill Selma Ste. 102, San Antonio, TX 78249
Phone & Fax: 210-485-1488 (p) / 210-485-1489 (f)

- I understand that this authorization sall be valid for 1 year from date signed, but that I may revoke it in writing at any time; any such recvocation shall have no effect on disclosures made previously.
- I understand that I have the right to inspect and copy the information to be released.
- I understand that if I refuse to consent to disclosure of information, the agency may be unable to serve me and/pr may be unable to provide the most appropriate care for me.
- I understand that the release of information may not be re-released to any other person or organization without my written consent.

Signature:_____ Date:_____