PLEASE FAX THIS FORM TO 301-654-9132 OR MAIL IT TO OUR OFFICE

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION FROM ANOTHER DOCTOR OR INSTITUTION

This Authorization form is designed to meet the requirements of federal privacy regulations issued by the Department of Health and Human Services at 42 CFR § 164.508 and the Annotated Code of Maryland, Title 10 Health General Article §§ 4-301-4-307.

I hereby authorize Name: _____
Address: _____
Telephone: _____
Fax: _____

to release the protected health information of:

PATIENT: _____

DATE OF BIRTH: _____ PHONE: _____

ADDRESS: _____

The information is to be released to:

WASHINGTON EYE PHYSICIANS AND SURGEONS
5454 WISCONSIN AVE., Suite 950
CHEVY CHASE, MD 20815
P: 301-657-5700
F: 301-654-9132

The information I wish to have released is (include dates of service):

- ☐ Discharge summary
- ☐ History and physical exam
- ☐ Consultation reports
- ☐ Reports of operations
- ☐ Imaging reports
- ☐ Laboratory reports
- ☐ Other_____

The purpose for such disclosure is:

☐ At my request (only patient may check) ☐ Payment/Insurance

☐ Healthcare ☐ Employment

This authorization will expire one year from the date it is signed unless a shorter time

is indicated here:

_____

I understand:

- This authorization is voluntary.
- My treatment, payment for it and/or eligibility for enrollment or benefits cannot be conditioned on my signing this authorization form.
- I may receive a copy of this form.
- I may inspect my protected health information without signing this form.
- This authorization to disclose information may be revoked by me at any time, except to the extent that the action has been taken prior to receipt of revocation. To revoke the authorization, I understand that I must notify ***Washington Eye Physicians & Surgeons*** in writing.
- I understand that once information covered by this authorization has been disclosed, re disclosure of information by that recipient is possible and the information may no longer be protected by the federal regulations referenced above but may be protected by Maryland law.

_____ _____

Patient or Personal Representative's Signature Date

If signature is other than patient, explain your authority to act for the patient:

_____

_____

_____