Authorization For Release of Individually Identified Health Information

OPHTHALMOLOGY associates

Patient name:_____ **Date of Birth:**_____

I, or my personal representative, hereby authorize Ophthalmology Associates to use or disclose protected health information regarding my care and treatment.

Provider releasing this information (one provider per form)**:**

Name: _____

Address: _____

Phone / Fax: _____

Purpose for release of information:

☐ At my request ☐ Continuity of Care

☐ Other: _____

Who will be receiving this information:

☐ Send to: _____

Address: _____

Phone / Fax: _____

☐ I will pick it up ☐ My personal representative _____

(Identification required for pick-up)

Description of information being released:

I would like (choose one):

☐ Specific Dates: _____

☐ My entire Medical Record

☐ Other: _____

Signature: _____ **Date:** _____ / _____ / _____

Print name of patient or personal representative: _____

Personal representative's authority (supporting documentation required):

☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Administrator / Executor

☐ Other: _____

****An administrative fee may apply and will be determined upon review****

12990 Manchester Road • Suite 200 • Des Peres, Missouri 63131
Office: (314) 966-5000 • After Hours: (314) 388-5354 • Facsimile: (314) 909-6666