SILVERSTEIN EYE CENTERS P.C.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, *(Please Print)* **Patient Name**_____ **Date of Birth** _____
authorize the release of a copy of my medical records.

FROM: _____
Practice/Facility or Physician Name *Address* *Phone and fax number*

TO: _____
Recipient of patient records *Address* *Phone and fax number*

Please Provide Records Via:

- ☐ Mailing Address: _____
- ☐ FAX Number: _____
- ☐ Encrypted Email: _____
- ☐ Pick up in office

Purpose of disclosure: _____
e.g. Moving, Changed Insurance, Continuation of Care, Referral, Legal proceedings, etc.

I specifically authorize the release of the following:

_____
Specify all or what portion of records

I expressly and voluntarily authorize disclosure of the above medical record information. I further understand that I am not giving permission for any disclosure other than described above. I understand that if my medical record contains information concerning HIV (AIDS) or drug or alcohol abuse, those portions of my medical record are protected by state or federal law. I understand that the information disclosed may include sensitive and confidential medical information, including but not limited to diagnosis, treatment, and medication history. I hereby release and forever discharge Silverstein Eye Centers, the physicians and employees, or agents from any liability arising out of the release of my medical record as specified above and pursuant to this signed authorization.

I understand that this authorization is voluntary and that I may refuse to sign this form. I also understand that I may revoke this authorization at any time, except to the extent that action has been taken in reliance on it. If not previously revoked, this authorization will expire: _____. If left blank, this consent expires in one year.

Information disclosed as requested in this authorization may be subject to re-disclosure by the Recipient and may no longer be protected by federal HIPAA rule. Treatment may not be conditioned on signing this authorization unless treatment is research related and the authorization is for use or disclosure for such research.

Patient Signature: _____ Date: _____

Guardian: _____ Relationship: _____
Signature of parent, guardian, or authorized representative

Witness: _____ Date: _____