AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

All sections of this authorization must contain a response.

HIPAA requires that the minimum amount of information necessary be shared; therefore, please be as specific as possible. For example, if you have been a long-time patient, and you are moving out of the area, your new doctor does not need or want your entire medical record. Most likely they only want the last comprehensive visit. Likewise, if you are obtaining records for a second opinion, you will only need records related to that issue for which you are seeking a second opinion (you can always ask for additional information later).

WHO	Patient Name:	Date of Birth:
WHAT	Records to be Released **from Riverside EyeCare Professionals** (only those necessary): ☐Specific records: ☐Any information needed to complete referenced form(s) ☐All records, except HIV, AIDS, drug & alcohol abuse records – limited to 2 years	
WHEN	Date Range of Records to be Released (only those necessary): Beginning: Ending: ☐As necessary for form completion	
WHERE	Release Records To or Complete Form For: Name: Address:	
WHY	☐Treatment or Review by another Doctor ☐For Personal File ☐To Complete Form ☐Other:	
HOW	☐Please mail copies or completed form ☐I will pick up copies or completed form ☐Other:	

This release is for one-time use only and shall expire immediately upon fulfillment of the request.

Signature ☐Patient ☐Guardian ☐POA	Date Signed	Witness Signature