Authorization to Release Records

Patient Name: _____

Patient Address: _____

_____

Date of Birth: _____

Previous Provider/ Office : _____

I hereby authorize this practice to disclose my protected health information (information about me in my medical record and/or financial record) as indicated below

The information is to be disclosed to (check one):

☐ Independence Eye Associates, PC
365 Faunce Corner Road
North Dartmouth, MA 02747
Fax # (508) 995-1152

☐ Other: _____
_____
_____

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice.
- I may be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- The practice may not condition treatment or payment based on my signing this authorization.
- I am signing this authorization freely.
- No one has pressured me to sign this authorization.
- The information disclosed in this authorization may be subject to re-disclosure by the practice and no longer protected by federal law.
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and the use.

Patient Signature: _____
Or
Signature of Representative: _____

Relation: _____

Date: _____