Universal Eye Center
Dr. David Dickman
310 S Main St.
Rolesville, NC 27571
Phone: 919-438-3937
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HIPPA COMPLIANT AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The Medical records cannot be released until this form is completed and signed by the patient or legal guardian.
You must complete this form thoroughly.

PLEASE PRINT

Patient Name _____ Date of Birth _____

Address _____

I hereby authorize Dr. David Dickman (Universal Eye Center) _____ to release OR _____ obtain my health information.

Name of Physician/ Medical Facility _____

Address _____

Phone # _____ Fax # _____

Information to be released:

_____ Medical Records from (date) _____ to (date)

_____ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, referrals, consults, billing records, insurance records, and records sent by other health care providers.

_____ OTHER: _____

PLEASE INITIAL BELOW TO INCLUDE THE FOLLOWING:

_____ ALCOHOL/DRUG TREATMENT _____ HIV – RELATED INFORMATION

_____ MENTAL HEALTH INFORMATION (EXCLUDING psychotherapy notes)

_____ GENETIC TESTING

Purpose for this disclosure is at the request of the individual based on the following: (This section must be completed before records will be released)

_____ Continuity of care Reason: _____

_____ Transfer of care

CONDITIONS OF AUTHORIZATION

I have the right to revoke this authorization at any time by writing to the health care provider listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. I understand that signing this form is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State privacy regulations. A copy of this authorization has been provided. This authorization is valid for 90 days for the release of information as indicated by date of signature below.

_____ _____

Patient Signature and Date

If not the patient, name and authority to sign on their behalf