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ELHOSN
EYE & AESTHETICS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Phone Number: _____

Address: _____ City/State/Zip: _____

The Above listed Patient authorizes the following healthcare provider / facility to release and disclose their medical records and information:

Provider / Facility: _____

Phone Number: _____ Fax Number: _____

Address: _____ City/State/Zip: _____

Type of information to be disclosed: Exam Notes, Visual Fields, OCT's, Operative Reports, IOL Master Reports, and any other testing the patient may have had.

The information may be released, disclosed, and used by:

Elhosn Eye and Aesthetics

Ramsey Elhosn, MD / Katina Villas, MD

4 Executive Park Drive Albany, NY 12203

Phone: 518-487-4200 Fax: 518-708-6896

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.S24. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure on my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of the Authorization.

Signature of Patient/Parent/Guardian: _____ Date: _____

Printed Name of Patient/ Parent / Guardian: _____ Relationship: _____