Ozark Retina & Macula
1230 E. Kingsley
Springfield, MO 65804
(417) 720-4916
Fax (417) 720-4917
Toll Free 844-473-5959
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Release of Records from Ozark Retina & Macula

Authorization for Release of Identifying Health Information

Patient Name: _____ Date of Birth: _____

Patient Phone #: _____ Account #: _____

Patient Address: _____

The professional office named above is authorized to release health information identifying the patient named above under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom the information will be released:
3. The purpose for the release:
4. Expiration date or event:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. Our *Notice of Privacy Practices* explains how you may request access to your identifiable health information, and how we may respond. You simply need to send a written request to the office contact person to initiate the process.

If you sign this authorization, you can revoke it later, except if we have already acted in reliance upon authorization. If you wish to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed above.

We (will/will not) receive a financial benefit from disclosing this health information about you.

I have read and understand this form. I am signing it voluntarily. I authorize the disclosure of my health information as described above.

_____ _____

Signature **Date**

If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form:

_____ _____

Relationship to Patient Print Name

Source of Authority: _____