Ozark Retina & Macula
1230 E. Kingsley
Springfield, MO 65804
(417) 720-4916
Fax (417) 720-4917
Toll Free 844-473-5959
www.ozarkretina.com

Release of Records to Ozark Retina & Macula

Name of Doctor or Practice: _____

Address: _____

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 to Ozark Retina & Macula identifying the patient named above under the following terms and conditions:

1. Detailed description of the information to be released: ALL
2. To whom the information will be released: OZARK RETINA & MACULA
3. The purpose for the release: UPCOMING APPOINTMENT(S)
4. Expiration date or event: ONE YEAR FROM DATE OF PATIENT SIGNATURE

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.

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.

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: _____