GINSBERG EYE
OPHTHALMOLOGY

For the purpose of patient care, I hereby request and authorize the following organization or individual to release my medical records to ____ as specified in this release.
(name of organization or individual authorized to release or obtain PHI)

AUTHORIZATION TO RELEASE/OBTAIN HEALTHCARE INFORMATION

Patient's Name: ___________________________ Date of Birth: _____________________________

Previous Name: ___________________________ Social Security #: __________________________

I request and authorize ____

(name of organization or individual authorized to release or obtain information)

to release healthcare information of the patient named above to:

Name: Ginsberg Eye

Address: 77 8th Street South
Naples, FL 34102

Phone: 239.325.2015 Fax: 239.325.2014

This request and authorization applies to:
Healthcare information relating to the following treatment, condition, or dates: ______________________________

____

____

All healthcare information
Other: ____

Patient/Representative
Signature: ____ Date
Signed: ____________________________

Relationship to Patient: _______________________________________ Witness: ___________________________

I understand that my authorization will remain effective from the date of my signature for 365 days after, and that the information will be handled confidentially in compliance with all applicable federal laws.
I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

Patient Name: ____ Date of Birth: ____________________________