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: 9441 Corkscrew Palms Circle, Suite 201
Estero, FL 33928

Phone: 239.325.2020 Fax: 239.325.2016

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: _____